

# **REFERRAL CHANGES AND OTHER REVISIONS**

## **2023 Interim Meeting**

### **REFERRAL CHANGES**

- Res. 920 – Antipsychotic Medication Use for Hospice Patients, has been reassigned to Reference Committee B and is now Res. 225

### **WITHDRAWN REPORTS**

- BOT 11 – Criminalization of Providing Medical Care

### **REVISED REPORTS**

- BOT 12 – American Medical Association Meeting Venues and Accessibility (v2)

### **RESOLUTIONS WITH ADDITIONAL SPONSORS**

**(Additional sponsors underlined)**

- Res. 207 – On-Site Physician Requirement for Emergency Departments (Michigan, Texas)
- Res. 806 – Evidence-Based Anti-Obesity Medication as a Covered Benefit (Michigan, Obesity Medicine Association, Endocrine Society)
- Res. 821 - Modernizing the AMA/Specialty Society RVS Update Committee (RUC) Processes (American College of Physicians, American Academy of Family Physicians, Florida Medical Association, The Society for Post-Acute and Long Term Care Medicine, Renal Physicians Association and Oregon Medical Association)

**ORDER OF BUSINESS  
SECOND SESSION**

**Saturday, November 11, 2023  
12:30 PM**

- 1. Call to Order by the Speaker – Lisa Bohman Egbert, MD**
- 2. Report of the Rules and Credentials Committee – Christopher Garofalo, MD**
- 3. Presentation Correction and Adoption of Minutes from the June 2023 Annual Meeting**
- 4. Referral Changes and Other Revisions**
- 5. Acceptance of Business**

**--REPORTS--**

**Report(s) of the Board of Trustees - Willie Underwood, III, MD, MSc, MPH, Chair**

- 01 Employed Physicians (Amendments to C&B)
  - 02 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies (K)
  - 05 AMA Public Health Strategy: The Mental Health Crisis (K)
  - 06 Universal Good Samaritan Statute (B)
  - 07 Obtaining Professional Recognition for Medical Service Professionals (B)
- 10 Medical Decision-Making Autonomy of the Attending Physician (Amendments to C&B)
- 12\* American Medical Association Meeting Venues and Accessibility (F) (REVISED v2)
  - 13 House of Delegates (HOD) Modernization (F)
  - 14 Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home (K)
- 17\* Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)

**Report(s) of the Council on Ethical and Judicial Affairs - David A. Fleming, MD, Chair**

- 01 Physicians' Use of Social Media for Product Promotion and Compensation (Amendments to C&B)
- 02 Research Handling of De-Identified Patient Data (Amendments to C&B)

**Report(s) of the Council on Long Range Planning and Development - Gary Thal, MD, Chair**

- 01 Women Physicians Section Five-Year Review (F)

**Report(s) of the Council on Medical Education - Cynthia Jumper, MD, MPH, Chair**

- 01 Leave Policies for Medical Students, Residents, Fellows, and Physicians (C)
- 02 Update on Continuing Board Certification (C)
- 03 Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education (C)
- 04 Recognizing Specialty Certifications for Physicians (C)
- 05 Organizations to Represent the Interests of Resident and Fellow Physicians (C)

**Report(s) of the Council on Medical Service - Sheila Rege, MD, Chair**

- 01 ACO REACH (J)
- 02 Health Insurers and Collection of Patient Cost-Sharing (J)
- 03 Strengthening Network Adequacy (J)
- 05 Medicaid Unwinding Update (J)
- 06 Rural Hospital Payment Models (J)
- 07 Sustainable Payment for Community Practices (J)

**Report(s) of the Council on Science and Public Health - David J. Welsh, MD, MBA, Chair**

- 01 Drug Shortages: 2023 Update (K)
- 02 Precision Medicine and Health Equity (K)
- 03 HPV-Associated Cancer Prevention (K)
- 04 Supporting and Funding Sobering Centers (K)
- 05 Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room (K)
- 06 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use (K)
- 07 Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities (K)

**Report(s) of the HOD Committee on Compensation of the Officers-Claudette Dalton, MD, Chair**

- 01 Report of the House of Delegates Committee on the Compensation of the Officers (F)

**Report(s) of the Speakers - Lisa Bohman Egbert, MD, Speaker; John H. Armstrong, MD, Vice Speaker**

- 02 Extending Online Forum Trial Through A-24 (F)
- 03 Report of the Election Task Force 2 (Amendments to C&B)

**--EXTRACTION OF INFORMATIONAL REPORTS--**

**BOT Report(s)**

- 03 Update on Climate Change and Health – AMA Activities
- 04 Update on Firearm Injury Prevention Task Force
- 08 AMA Efforts on Medicare Payment Reform
- 09 Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted
- 15 Redefining AMA's Position on ACA and Health Care Reform
- 16 2023 AMA Advocacy Efforts

**CEJA Opinion(s)**

- 01 Responsibilities to Promote Equitable Care

**CLRPD Report(s)**

- 02 Generative AI in Medicine and Health Care

**CME Report(s)**

- 02 Update on Continuing Board Certification

**CMS Report(s)**

- 04 Physician-Owned Hospitals

**Report(s) of the Speakers**

- 01 Report of the Resolution Modernization Task Force Update

## **--INTRODUCTION OF RESOLUTIONS--**

- 002 Support for International Aid for Reproductive Healthcare (Amendments to C&B)
- 004 Reconsideration of Medical Aid in Dying (MAID) (Amendments to C&B)
- 005 Adopting a Neutral Stance on Medical Aid in Dying (Amendments to C&B)
- 006 Inappropriate Use of Health Records in Criminal Proceedings (Amendments to C&B)
- 007 Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers (Amendments to C&B)
- 009 Physicians arrested for Non-Violent Crimes While Engaged in Public Protests (Amendments to C&B)
- 201 Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care (B)
- 202 Protecting the Health of Patients Incarcerated in For-Profit Prisons (B)
- 203 Anti-Discrimination Protections for Housing Vouchers (B)
- 204 Improving PrEP & PEP Access (B)
- 205 Cannabis Product Safety (B)
- 206 The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice (B)
- 207 On-Site Physician Requirement for Emergency Departments (B)
- 208 Non-Physician Practitioners Oversight and Training (B)
- 210 Immigration Status in Medicaid and CHIP (B)
- 213 Health Technology Accessibility for Aging Patients (B)
- 215 A Public Health-Centered Criminal Justice System (B)
- 216 Saving Traditional Medicare (B)
- 217 Addressing Work Requirements for J-1 Visa Waiver Physicians (B)
- 218 Youth Residential Treatment Program Regulation (B)
- 219 Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD) (B)
- 220 Merit-Based Process for the Selection of all Federal Administrative Law Judges (B)
- 222 Expansion of Remote Digital Laboratory Access Under CLIA (B)
- 223 Initial Consultation for Clinical Trials Under Medicare Advantage (B)
- 224 ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers (B)
- 226\* Delay Imminent Proposed Changes to U.S. Census Questions Regarding Disability (B)
- 234\* Pharmacy Benefit Manager (PBM) Control of Treating Disease States (B)
- 301 Clarification of AMA Policy D-310-948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” (C)
- 302 Medical Student Reports of Disability-Related Mistreatment (C)
- 304 Health Insurance Options for Medical Students (C)
- 305 Addressing Burnout and Physician Shortages for Public Health (C)
- 306 Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies (C)
- 307\* Re-evaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program (C)
- 601 Carbon Pricing to Address Climate Change (F)
- 606 Prevention of Healthcare-Related Scams (F)
- 801 Improving Pharmaceutical Access and Affordability (J)
- 802 Improving Nonprofit Hospital Charity Care Policies (J)
- 803 Improving Medicaid and CHIP Access and Affordability (J)
- 804 Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity (J)
- 805 Medication Reconciliation Education (J)
- 806 Evidence-Based Anti-Obesity Medication as a Covered Benefit (J)
- 807 Any Willing Provider (J)
- 808 Prosthodontic Coverage after Oncologic Reconstruction (J)

- 809 Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion (J)
- 811 Expanding the Use of Medical Interpreters (J)
- 812 Indian Health Service Improvements (J)
- 813 Strengthening Efforts Against Horizontal & Vertical Consolidation (J)
- 814 Providing Parity for Medicare Facility Fees (J)
- 815 Long-Term Care and Support Services for Seniors (J)
- 817 Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations (J)
- 818 Amendment to AMA policy on healthcare system reform proposals (J)
- 819 Amend Virtual Credit Card Policy (J)
- 820 Affordability and Accessibility of Treatment of Overweight and Obesity (J)
- 821\* Modernizing the AMA/Specialty Society RVS Update Committee (RUC) Processes (J)
- 901 Silicosis from Work with Engineered Stone (K)
- 902 Post Market Research Trials (K)
- 903 Supporting Emergency Anti-Seizure Interventions (K)
- 904 Universal Return-to-Play Protocols (K)
- 905 Support for Research on the Relationship Between Estrogen and Migraine (K)
- 906 Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices (K)
- 909 High Risk HPV Subtypes in Minoritized Populations (K)
- 910 Sickle Cell Disease Workforce (K)
- 913 Public Health Impacts of Industrialized Farms (K)
- 914 Adverse Childhood Experiences (K)
- 915 Social Media Impact on Youth Mental Health (K)
- 916 Elimination of Buprenorphine Dose Limits (K)
- 921 Addressing Disparities and Lack of Research for Endometriosis (K)
- 922 Prescription Drug Shortages and Pharmacy Inventories (K)
- 923\* Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation (K)

**--RESOLUTIONS NOT FOR CONSIDERATION--**

- 001 Physician-Patient Communications in the Digital Era
- 003 Guardianship and Conservatorship Reform
- 008 AMA Executive Vice President
- 209 Opposing Pay-to-Stay Incarceration Fees
- 211 Indian Water Rights
- 212 Medical-Legal Partnerships & Legal Aid Services
- 214 Humanitarian Efforts to Resettle Refugees
- 221 Support for Physicians Pursuing Collective Bargaining and Unionization
- 227\* Reforming Stark Law's Blanket Self-Referral Ban
- 228\* The Employee Retirement Income Security Act of 1974 Revisited
- 229\* Facilitating Appropriate Reimbursement of Diagnostic Radiopharmaceuticals
- 230\* The Corporate Practice of Medicine, Revisited
- 231\* Deceptive Hospital Badging 2.0
- 232\* Access to Covered Benefits with an Out of Network Ordering Physician
- 233\* Corporate Practice of Medicine Prohibition
- 303 Fairness for International Medical Students
- 308\* Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations
- 309\* The Role of Maintenance of Certification
- 602 Inclusive Language for Immigrants in Relevant Past and Future AMA Policies
- 603 Improving the Efficiency of the House of Delegates Resolution Process
- 604 Updating Language Regarding Families and Pregnant Persons
- 605 Ranked Choice Voting
- 607 Equity-Focused Person-First Language in AMA Reports and Policies
- 608 Confronting Ageism in Medicine
- 609\* Advocacy Education Towards a Sustainable Medical Care System
- 610\* End Attacks on Health and Human Rights in Palestine and Israel
- 810 Racial Misclassification
- 816 Reducing Barriers to Gender-Affirming Care through Improved Payment and Reimbursement
- 822\* Upholding Physician Autonomy in Evidence -Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation
- 907 Occupational Screenings for Lung Disease
- 908 Sexuality and Reproductive Health Education
- 911 Support for Research on the Nutritional and Other Impacts of Plant-Based Meat
- 912 Fragrance Regulation
- 917 Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals
- 918 Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
- 919 Lithium Battery Safety

**--AMPAC REPORT--**

**--MEMORIAL RESOLUTIONS—**

**--REPORT OF THE COMMITTEE ON RULES AND CREDENTIALS – CHRISTOPHER  
GAROFALO, MD**

\* Contained in the Meeting Tote

## **Report of the AMPAC Board of Directors**

Presented by: Brooke M. Buckley, MD  
Chair

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On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities this election cycle. The country continues to face a myriad of challenges in health care, including many that directly impact physician practices and their patients. Issues like the ever-looming cuts to physician Medicare payments, time consuming prior authorizations and sky rocketing prescription drug costs remain as major roadblocks to how physicians provide quality care for their patients.

The continuing challenges faced by the medical community have only strengthened our commitment to our core mission - to provide physicians with opportunities to support candidates for federal office who have demonstrated their support for organized medicine through a willingness to work with physicians to strengthen our ability to care for America's patients. In addition, we continue to help physician advocates grow their abilities through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully take the next step and work on campaigns or run for office themselves.

### **AMPAC Membership Fundraising**

The AMPAC Board thanks House of Delegate members who have already made a contribution to AMPAC this year and committed to supporting advocacy, especially those who gave at the Capitol Club levels. Your generosity enables AMPAC to advance the AMA's advocacy initiatives as we enter an important election year and build a solid foundation for our allies and champions running for federal office in 2024.

This year, AMPAC has moved into a period of growth in all areas and has seen a 17 percent increase in receipts over this same time in the 2021-2022 election cycle. Additionally, AMPAC's Capitol Club continues to trend upwards with 723 members, above the 2021 non-election year total of 620 which is a 16 percent increase. Growth is expected to continue during this meeting to close out the year.

Each year, AMPAC aims to achieve 100 percent HOD AMPAC participation within AMA's House of Delegates. AMPAC ended 2022 with 69 percent HOD participation, and this year AMPAC has 71 percent participation. While this is encouraging movement in the right direction, it is far lower than the all-time high of 76 percent HOD AMPAC participation in 2019. With a significant election cycle already underway, AMPAC strongly encourages leaders of the House of Medicine to invest in AMPAC. Please stop by AMPAC's booth which is located outside the ballroom during this meeting to contribute for 2023 if you have not done so already and consider making your commitment for 2024. You can also visit <https://www.ampaonline.org>

Last, all current 2023 Capitol Club members are invited to attend a Capitol Club event on Monday, November 13 at 12 p.m. with special guest Congressman Greg Murphy (NC-3) to discuss the top legislative issues facing physicians today. Dr. Murphy has partnered with the AMA on several important legislative priorities and is known to be balanced, and well respected. It is sure to be an informative event you will not want to miss so visit AMPAC's booth to pick up your event ticket and Capitol Club gift.

AMPAC is the bi-partisan political action committee of the AMA that was created to advance the advocacy mission set forth by the HOD. We can only be as effective as we are united in our efforts to support this



political tool and further the AMA's advocacy initiatives. We hope to count on the support of all HOD members to boost overall AMPAC efficacy.

### **Political Action**

AMPAC remains in the early giving period of the 2024 election cycle. As such, contributions have been prioritized for incumbents who are strong allies of medicine, members of their parties' leadership, on key committees or otherwise in important positions to advance medicine-friendly policies on Capitol Hill. The AMA's intense focus on Medicare physician payment reform and efforts to rally support behind MEI-related legislation in Congress has helped to further guide AMPAC's strategy in creating opportunities for lobbyists to attend events with lawmakers who are integral to this effort. The pace of AMPAC contributions is likely to increase as the end of the year approaches and the need for increased face time with these and other key legislators ratchets up. Another emerging consideration is early 2024 primary states as some of the more competitive races are already in full swing.

While the overall political landscape remains murky, AMPAC remains well-positioned to take part in key races around the country and ensure that the AMA's message is properly communicated on Medicare and other key issues facing America's physicians.

### **Political Education Programs**

The 2023 Campaign School took place in-person, October 12-15, at the AMA offices in Washington, DC. Registration for the program was strong with 18 registrants. This included: 14 member physicians and four member students. Unfortunately, some of the registrants had to back out due to travel and medical reasons leaving 14 participants at the program. Of these, three had also taken part in the 2023 Candidate Workshop in late March. The Campaign School is renowned for its use of a simulated campaign for the U.S. House of Representatives, complete with demographics, voting statistics and detailed candidate biographies. During the three-day program participants were placed into campaign teams and with a hands-on approach, our team of bipartisan political experts walked them through a simulated campaign and applied what they learn in real-time exercises on strategy, vote targeting, social media, paid advertising, and public speaking. The program was capped off with a keynote session with Senator John Barrasso, MD of Wyoming.

Planning is currently underway for the 2024 Candidate Workshop. AMPAC is working with the program's lead trainer to identify dates in the spring and the program will be held in-person again at the AMA offices in Washington, DC. As always, the political education programs remain a member benefit with registration fees heavily discounted for AMA members. Program dates will be announced soon on AMPACOnline.org.

### **Conclusion**

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates who support AMPAC and the work we do. Your continued involvement in political and grassroots activities ensures organized medicine a powerful voice in Washington, DC.

# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

## **Memorial Resolution**

**Carol E. Rose, MD**

**Introduced by Jill Owens, MD, Chair; John P. Williams, MD, Delegate, James D. Grant, MD,  
Delegate On behalf of the Pennsylvania Delegation and American Society of  
Anesthesiologists Delegation**

Whereas, Carol E. Rose MD, passed away on October 16, 2023, at Family Hospice in Pittsburgh, PA; and

Whereas,, Dr. Rose had an enduring impact on those who were fortunate enough to work with her. She was a board-certified anesthesiologist at University of Pittsburgh Medical Center, associate professor of anesthesiology at the University of Pittsburgh School of Medicine, and later served on staff at Western Psych; and

Whereas, Dr. Rose embarked on her medical journey, graduating from the University of Miami (1978), defying norms and expectations as one of the few women among her peers, with the added distinction of being one of the more mature medical students at 33 years old; and

Whereas, Dr. Rose completed her residency at Mercy Hospital, now known as UPMC Mercy. After spending eight years at South Side Hospital, she worked at UPMC for 19 years. Dr. Rose assumed the role of director of electroconvulsive therapy anesthesiology and skillfully managed a dedicated team and provided invaluable anesthesia services to patients and making indelible marks in the field of anesthesiology; and

Whereas, Dr. Rose was actively engaged with both local and national medical organizations. She was highly involved with the Allegheny County Medical Society in Pennsylvania serving as Board of Director (2008) and advocated for Allegheny County to have its own district in the Pennsylvania Medical Society; and

Whereas,, Dr. Rose was dedicated to and a long-standing member of the Pennsylvania Medical Society, ascending to the position of Trustee (1992-2002). She achieved the historic milestone of becoming the Pennsylvania Medical Society's first female President (2001-2002); and

Whereas, Dr. Rose's exemplary leadership extended to the Pennsylvania Society of Anesthesiologists, where she served as President (1995-1996), as well as her role as a leader in the American Society of Anesthesiologists (ASA) delegation to the American Medical Association and a long-standing member of the Pennsylvania delegation to the American Society of Anesthesiologists. Dr. Rose was the pre-eminent coordinator of the ASA Delegation uniform selection, a role which she relished; and

Whereas,, She was elected as Chair of the Pennsylvania State Board of Medicine (2010-2011). She retired from her clinical practice at this time to focus on this pivotal role; and

Whereas,, Dr. Rose served on the Foundation of the Pennsylvania Medical Society Board of Trustees from 2001-2002. She was the first chair of the Foundation's Student Financial Service Committee in 2005 and would speak about financial health for medical students during seminars at the various medical schools. She was a life-long advocate for medical students and designated the Foundation of the Pennsylvania Medical Society as the charitable recipient of memorial funds to reflect her commitment to the accessibility of funds for the education of medical students; and

Whereas, Dr. Rose was a well-respected clinician and leader recognized for her professionalism, and valued by her patients; and

Whereas, Dr. Rose is survived by her husband of sixty-three years, Byron, who actively supported and encouraged her to pursue her dream of being a physician and her work for the profession; and therefore be it

RESOLVED, that the House of Delegates recognize Dr. Rose's passing with a moment of silence; and be it further

RESOLVED, that this resolution be recorded and presented to Dr. Rose's Family.

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

## Supplementary Report of Committee on Rules and Credentials (I-23)

Presented by: Christopher Garofalo, MD, Chair

Saturday, November 11, 2023

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1 Mister Speaker, Members of the House of Delegates:

### 2 3 (1) LATE RESOLUTIONS 4

5 The Committee on Rules and Credentials met Friday, November 10, to discuss Late Resolutions.  
6 The sponsors of the late resolutions met with the committee and were given the opportunity to  
7 present for the committee's consideration the reason the resolution could not be submitted in a  
8 timely fashion and the urgency of consideration by the House of Delegates at this meeting.  
9

10 Recommended for acceptance:

- 11 • Late 1002 – Laboratory Developed Tests Proposed FDA Rule

12  
13 Recommended against acceptance:

- 14 • Late 1001 – Preventing Imminent Payment Cuts and Ensuring the Sustainability of the  
15 Medicare Program
- 16 • Late 1003 – Treatment of Family Members

### 17 18 19 (2) REAFFIRMATION RESOLUTIONS 20

21 The Speakers asked the Committee on Rules and Credentials to review the recommendations  
22 for placing resolutions introduced at this meeting of the House of Delegates on the  
23 Reaffirmation Calendar. Reaffirmation of existing policy means that the policies reaffirmed  
24 remain active policies within the AMA policy database and therefore are part of the body of  
25 policy that can be used in setting the AMA's agenda. It also resets the sunset clock, so such  
26 policies will remain viable for 10 years from the date of reaffirmation. The Committee  
27 recommends that current policy be reaffirmed in lieu of the following resolutions (current policy  
28 and AMA activities are listed in the Appendix to this report):  
29

- 30 • Resolution 202 – Protecting the Health of Patients Incarcerated in For-Profit Prisons
- 31 • Resolution 204 – Improving PrEP & PEP Access
- 32 • Resolution 206 – The Influence of Large Language Models (LLMs) on Health Policy  
33 Formation and Scope of Practice
- 34 • Resolution 207 – On-Site Physician Requirement for Emergency Departments
- 35 • Resolution 208 – Non-Physician Practitioners Oversight and Training
- 36 • Resolution 210 – Immigration Status in Medicaid and CHIP
- 37 • Resolution 216 – Saving Traditional Medicare
- 38 • Resolution 305 – Addressing Burnout and Physician Shortages for Public Health
- 39 • Resolution 306 – Increasing Practice Viability for Female Physicians through Increased  
40 Employer and Employee Awareness of Protected Leave Policies
- 41 • Resolution 803 – Improving Medicaid and CHIP Access and Affordability

- Resolution 804 – Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity
- Resolution 807 – Any Willing Provider
- Resolution 808 – Prosthodontic Coverage after Oncologic Reconstruction
- Resolution 809 – Outsourcing of Administrative and Clinical Work to Different Time Zones - An Issue of Equity, Diversity, and Inclusion
- Resolution 814 – Providing Parity for Medicare Facility Fees
- Resolution 815 – Long-Term Care and Support for Seniors
- Resolution 817 – Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations
- Resolution 819 – Amend Virtual Credit Card Policy
- Resolution 821: Modernizing the AMA/Specialty Society Relative Value Scale Update Committee (RUC) Processes
- Resolution 915 – Social Media Impact on Youth Mental Health
- Resolution 922 – Prescription Drug Shortages and Pharmacy Inventories
- Resolution 923 – Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation

Mister Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Jerry P. Abraham, MD; Druv Bhagavan; Hillary Johnson-Jahangir, MD; Bhushan H. Pandya, MD; James W. Thomas, MD and Angela Wu, MD; and on behalf of the committee those who appeared before the committee.

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Jerry P. Abraham, MD, MPH  
California

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Bhushan H. Pandya, MD  
Virginia

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Druv Bhagavan  
Regional Medical Student, Missouri

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James W. Thomas, MD\*  
Pennsylvania

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Christopher Garofalo, MD, Chair  
Massachusetts

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Angela Wu, MD  
Sectional Resident and Fellow

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Hillary Johnson-Jahangir, MD  
American Academy of Dermatology

\*Alternate Delegate

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

Resolution 202 – Protecting the Health of Patients Incarcerated in For-Profit Prisons

- Health Care While Incarcerated H-430.986
- Standards of Care for Inmates of Correctional Facilities H-430.997

Resolution 204 – Improving PrEP & PEP Access

- HIV, Sexual Assault, and Violence H-20.900
- Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895.

Resolution 206 – The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice

- Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935. Augmented Intelligence in Health Care H-480.940
- Augmented Intelligence in Health Care H-480.939

Resolution 207 – On-Site Physician Requirement for Emergency Departments

- Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians D-35.976
- Scopes of Practice of Physician Extenders H-35.973
- Physician Assistants H-35.989
- Physician Assistants and Nurse Practitioners H-160.947
- Doctor of Nursing Practice H-35.970
- Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
- Models / Guidelines for Medical Health Care Teams H-160.906

Resolution 208 – Non-Physician Practitioners Oversight and Training

- Regulation of Physician Assistants H-35.965
- Physician Assistants H-35.989
- Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987
- Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners H-270.958
- Of note, Board of Trustees (BOT) Report 12, *Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners* (A-23) addressed this same issue and was adopted by the AMA's HOD at A-23

Resolution 210 – Immigration Status in Medicaid and CHIP

- Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
- Immigration Status is a Public Health Issue D-350.975

Resolution 216 – Saving Traditional Medicare

- Physician Payment Reform and Equity D-390.922
- Physician Payment Reform H-390.849
- Sequestration D-390.946

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

Resolution 305 – Addressing Burnout and Physician Shortages for Public Health

- Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327
- Funding for Preventive Medicine Residencies D-305.974
- Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion D-305.964
- Bolstering Public Health Preparedness H-440.892
- Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922,
- The Future of Public Health H-440.965
- Centers for Disease Control Funding H-440.982

Resolution 306 – Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies

- Policies for Parental, Family and Medical Necessity Leave H-405.960
- Parental Leave H-405.954

Resolution 803 – Improving Medicaid and CHIP Access and Affordability

- Empowering State Choice D-165.942
- Giving States New Options to Improve Coverage for the Poor D-165.966
- Medical Care for Patients with Low Incomes H-165.855
- Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
- Medicaid Waivers for Managed Care Demonstration Projects H-290.987

Resolution 804 – Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity

- Managed Care H-285.998
- Prior Authorization and Utilization Management Reform H-320.939
- Clinical Practice Guidelines and Clinical Quality Improvement Activities H-320.949
- Emerging Trends in Utilization Management H-320.958
- Utilization Review by Physicians H-320.973

Resolution 807 – Any Willing Provider

- Any Willing Provider Provisions and Laws H-285.984
- Tiered, Narrow, or Restricted Physician Networks D-285.972
- Network Adequacy H-285.908

Resolution 808 – Prosthodontic Coverage after Oncologic Reconstruction

- Definitions of “Cosmetic” and “Reconstructive” Surgery H-475.992

Resolution 809 – Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion

- Proper Use of Overseas Virtual Assistants in Medical Practice H-200.947
- Processing Prior Authorization Decisions D-320.979

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

Resolution 814 – Providing Parity for Medicare Facility Fees

- The Site-of-Service Differential D-330.902
- Discontinuance of Federal Funding for Ambulatory Care Centers H-240.993
- Intrusion by Hospitals into the Private Practice of Medicine H-240.979
- Advocacy and Action for a Sustainable Medical Care System D-385.945
- Physician Payment Reform and Equity D-390.922

Resolution 815 – Long-Term Care and Support for Seniors

- Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options D-280.982
- Financing of Long-Term Services and Supports H-280.945
- Policy Directions for the Financing of Long-Term Care H-280.991

Resolution 817 – Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations

- Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976
- Health Care Access for Medicaid Patients H-385.921
- CMMI Payment Reform Models D-385.950
- Alternative Payment Models and Vulnerable Populations D-385.952

Resolution 819 – Amend Virtual Credit Card Policy

- CMS Administrative Requirements D-190.970
- Physician Credit Card Payments by Health Insurance Companies D-190.972
- Virtual Credit Card Payments H-190.955
- Physician Choice of Practice H-385.926

Resolution 821 – Modernizing the AMA/Specialty Society Relative Value Scale Update Committee (RUC) Processes

- Arbitrary Relative Value Decisions by CMS D-400.983
- Non-Medicare Use of the RBRVS D-400.999
- RBRVS Development H-400.956
- Refining and Updating the Physician Work Component of the RBRVS H-400.959
- Refinement of Medicare Physician Payment System H-400.990



**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

Resolution 915 - Social Media Impact on Youth Mental Health

- H-478.976 Teens and Social Media

Resolution 922 - Prescription Drug Shortages and Pharmacy Inventories

- Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions H-120.923
- Third Party Payers Mandating Doctor and Patient Transfers of Prescriptions H-120.927
- Access to Medication H-120.920
- Safe and Efficient E-Prescribing H-120.921

Resolution 923 - Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation

- H-50.973 Blood Donor Deferral Criteria

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001  
(I-23)

Introduced by: Florida, American College of Physicians

Subject: Preventing Imminent Payment Cuts and Ensuring the Sustainability of the Medicare Program

Referred to: Reference Committee B

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1 Whereas, state and federal advocacy is one of the main reasons physicians join the American  
2 Medical Association and maintain membership in organized medicine; and  
3

4 Whereas, physicians have faced yearly reductions in the Medicare fee schedule  
5

6 Whereas, according to the final rule released November 2, 2023, physicians face a 3.4%  
7 Medicare pay cut in 2024; and  
8

9 Whereas, the economic sustainability of medical practices and access to care for Medicare  
10 beneficiaries is dependent on having a sustainable Medicare payment system, and  
11

12 Whereas, Medicare rates influence Medicare Advantage rates and private insurers' fee  
13 schedules and profoundly affect payments to all modalities of medical practice; and  
14

15 Whereas, the AMA has committed itself to preventing Medicare payment cuts and reforming the  
16 Medicare payment system; therefore be it  
17

18 RESOLVED, that our American Medical Association shall prioritize preventing the imminent  
19 3.4% Medicare payment cut from taking effect by any means available; and be it further  
20

21 RESOLVED, that our AMA shall continue to prioritize reforming the Medicare payment system  
22 to ensure the continued economic viability of medical practice; and be it further  
23

24 RESOLVED, that our AMA shall work towards achieving the highest sustainable annual  
25 Medicare payment increases possible, whether tied to the MEI, the CPI, or some other relevant  
26 measure of inflation that is sufficient to ensure that Medicare beneficiaries can receive robust  
27 access to care and that medical practices do not continue to encounter economic challenges as  
28 a result of insufficient payment updates, and be it further  
29

30 RESOLVED, that our AMA immediately create and disseminate, in major news outlets, a press  
31 release outlining the current problems within the Medicare system and how it will affect access  
32 to care with a call to action to help those with Medicare keep their physicians and the high  
33 quality care they deserve.

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 11/07/23

**References:** <https://fixmedicarenow.org/resources>

**Relevant AMA Policy:**

D-385.945 Advocacy and Action for a Sustainable Medical Care System

1. Our American Medical Association will declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA
2. Our AMA will prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index.
3. Our AMA Board of Trustees will report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002  
(I-23)

Introduced by: American Society for Clinical Pathology

Subject: Laboratory Developed Tests Proposed FDA Rule

Referred to: Reference Committee K

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1 Whereas, the federal Food and Drug Administration (FDA) mission includes the responsibility  
2 for protecting the public health by ensuring the safety, efficacy, and security of human and  
3 veterinary drugs, biological products, and medical devices; and  
4

5 Whereas, the FDA has previously communicated that it believes that the FDA has the authority  
6 to regulate laboratory developed tests (LDTs) as medical devices (in vitro diagnostic products –  
7 IVDs) under the Medical Device Amendments of 1976; and  
8

9 Whereas, since 1976 FDA has chosen to practice enforcement discretion, not requiring  
10 premarket approval or clearance for clinical laboratories to design and perform LDTs within the  
11 regulations set forth in the Clinical Laboratory Improvement Amendments of 1988 (CLIA); and  
12

13 Whereas, on October 3, 2023, FDA published to the Federal Register a proposed rule that  
14 would end this enforcement discretion and would require all LDTs to be approved or cleared as  
15 manufactured medical devices, effective at the time of finalization of the rule based on a four-  
16 year, five-step phase in period; and  
17

18 Whereas, previous proposed rules by FDA, and drafts of proposed legislation, have provided for  
19 more reasonable measures to assure appropriate clinical validation of LDTs under FDA  
20 oversight; and  
21

22 Whereas, LDTs play a crucial role in day-to-day medical care, including (but not limited to) the  
23 establishment of immunophenotypes for appropriate classification and treatment of leukemia  
24 and lymphoma, determining genetic and genomic status for purposes of determining  
25 appropriate treatment and appropriate screening per current standards of care, advanced  
26 chemical analysis methods for rapidly changing toxicology and therapeutic drug monitoring  
27 needs, tissue typing for transplant, and others; and  
28

29 Whereas, many clinical laboratories currently offering LDTs lack the infrastructure to meet the  
30 compliance standards suggested in the proposed rule, and enforcement of the rule would  
31 therefore risk loss of access to clinically necessary laboratory testing; and  
32

33 Whereas, LDTs have historically played a significant role in the development of new tests and  
34 diagnostic tools, implementations of the proposed regulations could impede the ability of  
35 laboratories to adapt quickly to emerging health threats and hinder the ability to conduct  
36 diagnostic advancements; and  
37

38 Whereas, specific areas within laboratory medicine, including histocompatibility (HLA) and  
39 forensic testing, have been granted exemptions under new federal regulations, acknowledging  
40 the anticipated challenges to ongoing patient care in transplantation and law enforcement, it is

1 therefore reasonable to consider that similar adjustments or leniencies in the proposed  
2 regulations could prove beneficial in other medical fields; and  
3

4 Whereas, current federal law (CLIA) already requires all laboratory tests (including LDTs) to  
5 meet very stringent and specific criteria for analytical validation of test performance  
6 characteristics prior to offering these tests to patients; therefore be it  
7

8 RESOLVED, that our American Medical Association submit a comment to the FDA proposed  
9 rule entitled “Medical Devices; Laboratory Developed Tests” (Published October 3, 2023)  
10 requesting a 60-day extension period to the current comment period.

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 11/8/2023

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1003  
(I-23)

Introduced by: Edmond B. Cabbabe, M.D.

Subject: Treatment of Family Members

Referred to: Reference Committee (Assigned by HOD)

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1 Whereas, the code of ethics of the American Medical Association (AMA) was written in the 19th  
2 century AD; and  
3

4 Whereas, the practice of medicine has taken giant steps since then in areas of diagnostic  
5 testing, medical records recordings, patient safety measures, documentations, verifications,  
6 consents, hospitals and outpatients credentialing of surgeons and procedurists, etc.; and  
7

8 Whereas, concerns about appropriateness of care, indications, and proper training of physicians  
9 performing a procedure, or a physician treating any patient has become a legal and ethical  
10 process witnessed by office, hospital, and medical facilities' staff including medical and non-  
11 medical personnel recording, and reviewing appropriateness of care besides the treating  
12 physicians; and  
13

14 Whereas, multiple documented surveys of specialists and PCPs showed that a large number of  
15 these physicians admitted treating family members when they felt comfortable and confident  
16 they can provide the best care for them; and  
17

18 Whereas, a much larger percentages of plastic, head and neck surgeons, dermatologists, have  
19 admitted treating their family members; and  
20

21 Whereas, the current code of ethics, as it is currently written, sadly label these physicians acts  
22 as unethical; and  
23

24 Whereas, many hospitals, and surgery centers have "discovered" lately this part of the code of  
25 ethics, and started enforcing it, therefore forcing the physicians to seek other venues to treat  
26 family members; and  
27

28 Whereas, rendering care or performing procedures outside approved facilities such as an  
29 uncredited office procedure room or un-accredited other facilities endanger the life and well-  
30 being of the patients; and  
31

32 Whereas, physicians ultimate concern is their patient's safety and wellbeing whether the patient  
33 is a family member, a staff person, a friend or none of these; therefore be it  
34

35 RESOLVED, that our American Medical Association HOD asks CEJA to review the current code  
36 of ethics as it relates to treating family members to safeguard our family members from being  
37 treated in unacceptable settings, and to support the removal of the stigmata of unethical  
38 behavior currently being labeled on physicians treating their family members; and be it further  
39

40 RESOLVED, that CEJA reports back to the HOD on this issue at A-24.  
41

Fiscal Note: Not Yet Determined  
Received: 11/10/23

REVISED  
**ORDER OF BUSINESS**

Reference Committee on Amendments to Constitution and Bylaws (I-23)  
Po-Yin Samuel Huang, MD, Chair

Saturday, November 11, 2023  
Potomac Ballroom A  
[Zoom Meeting Link](#) (view only)

Gaylord Maryland Resort and Convention Center  
National Harbor, Maryland

1. BOT Report 01 – Employed Physicians
2. BOT Report 02 - Medical Decision-Making Autonomy of the Attending Physician
3. BOT Report 17 - Specialty Society Representation in the House of Delegates—  
Five-Year Review
4. Speakers Report 03 - Report of the Election Task Force 2 - Recommendation 1 –  
Stickers, Buttons, and Pins
5. Speakers Report 03 - Report of the Election Task Force 2 - Recommendation 2 –  
Campaign Receptions
6. Speakers Report 03 – Report of the Election Task Force 2 - Recommendation 3-  
6 – Dinners, Suites and Such
7. Speakers Report 03 – Report of the Election Task Force 2 - Recommendations  
7-8 – Campaign Literature Electronic Communications Website and Social Media
8. Speakers Report 03 – Report of the Election Task Force 2 - Recommendations  
9-12 – Interviews
9. Speakers Report 03 – Report of the Election Task Force 2 - Recommendations  
13-14 – Voting Process and Election Session
10. Speakers Report 03 – Report of the Election Task Force 2 - Recommendations  
15-21 – Announcements and Nominations
11. Speakers Report 03 – Report of the Election Task Force 2 - Recommendations  
22-26 – Election Committee
12. Speakers Report 03 – Report of the Election Task Force 2 - Recommendations  
27-29 – Endorsements

Note: During the reference committee hearing, supplemental material may be sent to [AMARefComCB@gmail.com](mailto:AMARefComCB@gmail.com). Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. AMENDMENTS MUST BE EMAILED. This email address is NOT intended as a means to provide testimony, which should only be presented in on the Online Member Forum or orally to the committee. This address is only operational for the duration of the reference committee hearing.

Items in *italics* were placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing.

13. CEJA Report 01 - Physicians' Use of Social Media for Product Promotion and Compensation
14. CEJA Report 02 - Research Handling of De-Identified Patient Data
15. *Resolution 001 - Physician-Patient Communications in the Digital Era*
16. Resolution 002 - Support for International Aid for Reproductive Healthcare
17. *Resolution 003 – Guardianship and Conservatorship Reform*
18. Resolution 006 - Inappropriate Use of Health Records in Criminal Proceedings
19. Resolution 007- Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers
20. *Resolution 008 – AMA Executive Vice President*
21. Resolution 009 - Physicians Arrested for Non-Violent Crimes While Engaged in Public Protests
22. *Resolution Late 1003 – Treatment of Family Members*
23. Resolution 004 - Reconsideration of Medical Aid in Dying (MAID); and Resolution 005 – Adopting a Neutral Stance on Medical Aid in Dying

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## **ORDER OF BUSINESS**

Reference Committee B – Interim 2023 Meeting

Peter Amadio, MD, Chair

November 11, 2023

1:30pm EST

Zoom Link: [https://zoom.us/webinar/register/WN\\_I-II\\_fAbS9itse\\_dFRfVMA](https://zoom.us/webinar/register/WN_I-II_fAbS9itse_dFRfVMA)

Items in italics are currently on the Not For Consideration list, Reaffirmation Consent Calendar, or are late resolutions. The Chair will address these items at the start of the hearing.

1. BOT Report 06 – Universal Good Samaritan Statute
2. BOT Report 07 – Obtaining Professional Recognition for Medical Service Professionals
3. Resolution 201 – Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care  
Resolution 225 - Antipsychotic Medication use for Hospice Patients
4. Resolution 205 – Cannabis Product Safety
5. Resolution 218 – Youth Residential Treatment Program Regulation
6. Resolution 219 – Improving Access to Post-Acute Medical Care for Patients with

**Note:** During the reference committee hearing, supplemental material may be sent to [RefComB@ama-assn.org](mailto:RefComB@ama-assn.org). Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented in on the Online Forum or orally to the committee.

**When you email your amendment, you will receive a response, indicating that staff has received it. If you do not receive a response, we did NOT receive it and you must resend. Amendments must be formatted correctly with strikethroughs and underlines.**

**Participants with technical issues should email [HODMeetingSupport@ama-assn.org](mailto:HODMeetingSupport@ama-assn.org) (please include a phone number); someone will contact you back as soon as possible to assist. For urgent issues during the meeting, the HOD Hotline: 800-337-1599, will be available for assistance.**

Substance Use Disorder (SUD)

7. *Resolution 202 – Protecting the Health of Patients Incarcerated in For-Profit Prisons*
8. *Resolution 209 – Opposing Pay-to-Stay Incarceration Fees*
9. *Resolution 215 – A Public Health-Centered Criminal Justice System*
10. *Resolution 212 – Medical-Legal Partnerships & Legal Aid Services*
11. *Resolution 210 – Immigration Status in Medicaid and CHIP*
12. *Resolution 214 – Humanitarian Efforts to Resettle Refugees*
13. *Resolution 217 – Addressing Work Requirements for J-1 Visa Waiver Physicians*
14. *Resolution 204 – Improving PrEP & PEP Access*
15. *Resolution 207 – On-Site Physician Requirement for Emergency Departments*
16. *Resolution 208 – Non-Physician Practitioners Oversight and Training*
17. *Resolution 231 – Deceptive Hospital Badging 2.0*
18. *Resolution 216 – Saving Traditional Medicare*  
*Late Resolution 1001 – Preventing Imminent Payment Cuts and Ensuring the Sustainability of the Medicare Program*
19. *Resolution 232 – Access to Covered Benefits with an Out of Network Ordering Physician*
20. *Resolution 223 – Initial Consultation for Clinical Trials Under Medicare Advantage*
21. *Resolution 206 – The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice*
22. *Resolution 213 – Health Technology Accessibility for Aging Patients*
23. *Resolution 224 – ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers*
24. *Resolution 234 -- Pharmacy Benefit Manager (PBM) Control of Treating Disease States*

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25. Resolution 228 – The Employee Retirement Income Security Act (ERISA) of 1974 Revisited
26. Resolution 230 -- The Corporate Practice of Medicine, Revisited
27. Resolution 233 – Corporate Practice of Medicine Prohibition
28. Resolution 227 – Reforming Stark Law’s Blanket Self-Referral Ban
29. *Resolution 221 – Support for Physicians Pursuing Collective Bargaining and Unionization*
30. Resolution 203 – Anti-Discrimination Protections for Housing Vouchers
31. *Resolution 211 – Indian Water Rights*
32. Resolution 220 – Merit-Based Process for the Selection of all Federal Administrative Law Judges
33. Resolution 222 – Expansion of Remote Digital Laboratory Access Under CLIA
34. Resolution 226 – Delay Imminent Proposed Changes to U.S. Census Questions Regarding Disability
35. Resolution 229 -- Facilitating Appropriate Reimbursement of Diagnostic Radiopharmaceuticals

**Note:** During the reference committee hearing, supplemental material may be sent to [RefComB@ama-assn.org](mailto:RefComB@ama-assn.org). Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented in on the Online Forum or orally to the committee.

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**Participants with technical issues should email [HODMeetingSupport@ama-assn.org](mailto:HODMeetingSupport@ama-assn.org) (please include a phone number); someone will contact you back as soon as possible to assist. For urgent issues during the meeting, the HOD Hotline: 800-337-1599, will be available for assistance.**

## **ORDER OF BUSINESS**

Reference Committee C (I-23)  
Sarah Marsicek, MD, Chair

November 10, 2023  
Potomac C Ballroom

Gaylord Maryland Resort and Convention Center  
[Zoom link](#)

1. Resolution 302 – Medical Student Reports of Disability-Related Mistreatment
2. *Resolution 303 – Fairness for International Medical Students*
3. Resolution 304 – Health Insurance Options for Medical Students
4. Resolution 308 – Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations
5. Council on Medical Education Report 03 – Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education
6. Council on Medical Education Report 05 - Organizations to Represent the Interests of Resident and Fellow Trainees (Resolution 304-A-22)
7. Resolution 301 – Clarification of AMA Policy D-310-948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure”
8. *Resolution 305 – Addressing Burnout and Physician Shortages for Public Health*
9. Resolution 307 – Re-evaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program
10. Council on Medical Education Report 01 - Leave Policies for Medical Students and Physicians
11. *Resolution 306 – Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies*
12. Council on Medical Education Report 04 – Recognizing Specialty Certifications for Physicians (Res 316-I-22)
13. Resolution 309 - The Role of Maintenance of Certification

### Notes:

- Titles in *italics* represent items on Not For Consideration list, Reaffirmation Consent Calendar, or Informational Report Consent Calendar. The Chair will address these items at the start of the hearing.
- Amendments and supplemental material for Ref Com C must be sent to [meded@ama-assn.org](mailto:meded@ama-assn.org).
- Link to [business](#) documents (e.g., Preliminary Document, Handbook, Sat Tote).
- For technical assistance, email [HODMeetingSupport@ama-assn.org](mailto:HODMeetingSupport@ama-assn.org) or call 800-337-1599.

## **ORDER OF BUSINESS**

Reference Committee F (I-23)  
Rebecca L. Johnson, MD, Chair

November 11, 2023  
Maryland Ballroom

Gaylord Maryland Resort and Convention Center  
Maryland

Zoom Link: [https://zoom.us/webinar/register/WN\\_A1F1OxmuTDyGNY-fhEzr6A#/registration](https://zoom.us/webinar/register/WN_A1F1OxmuTDyGNY-fhEzr6A#/registration)

### **FINANCIAL**

1. Report of the House of Delegates Committee on the Compensation of the Officers

### **HOUSE OF DELEGATES**

2. Council on Long Range Planning and Development Report 1 - Women Physicians Section Five-Year Review
3. Board of Trustees Report 12 - American Medical Association Meeting Venues and Accessibility
4. Board of Trustees Report 13 - House of Delegates (HOD) Modernization
5. Speakers Report 2 - Extending Online Forum Trial Through A-24
6. *Resolution 603 - Improving the Efficiency of the House of Delegates Resolution Process*
7. *Resolution 605 - Ranked Choice Voting*

### **DIVERSITY, EQUITY, AND INCLUSION**

8. *Resolution 602 - Inclusive Language for Immigrants in Relevant Past and Future AMA Policies*
9. *Resolution 604 - Updating Language Regarding Families and Pregnant Persons*
10. *Resolution 607 - Equity-Focused Person-First Language in AMA Reports and Policies*
11. *Resolution 608 - Confronting Ageism in Medicine*

Note: Items in italics were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials should be sent to [referencecommittee@gmail.com](mailto:referencecommittee@gmail.com). Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents, and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee, and will only accept supplemental material for the duration of the reference committee hearing.

ENVIRONMENTAL

12. Resolution 601 - Carbon Pricing to Address Climate Change

MISCELLANEOUS

13. Resolution 606 - Prevention of Healthcare-Related Scams
14. *Resolution 609 – Advocacy Education Towards a Sustainable Medical Care System*
15. *Resolution 610 – End Attacks on Health and Human Rights in Palestine and Israel*

## **ORDER OF BUSINESS**

Reference Committee J (I-23)  
Man-Kit Leung, MD, Chair

November 11, 2023  
Potomac Ballroom D

Gaylord National Resort & Convention Center  
National Harbor, MD

1. Council on Medical Service Report 1 – ACO REACH
2. Council on Medical Service Report 2 – Health Insurers and Collection of Patient Cost-Sharing
3. Council on Medical Service Report 3 – Strengthening Network Adequacy
4. Council on Medical Service Report 5 – Medicaid Unwinding Update
5. Council on Medical Service Report 6 – Rural Hospital Payment Models
6. Council on Medical Service Report 7 – Sustainable Payment for Community Practices
7. Resolution 801 – Improving Pharmaceutical Access and Affordability
8. Resolution 805 – Medical Reconciliation Education
9. Resolution 802 – Improving Nonprofit Hospital Charity Care Policies
10. *Resolution 803 – Improving Medicaid and CHIP Access and Affordability*
11. *Resolution 807 – Any Willing Provider*
12. *Resolution 804 – Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity*
13. *Resolution 808 – Prosthodontic Coverage after Oncologic Reconstruction*
14. Resolution 806 – Evidence-Based Anti-Obesity Medication as a Covered Benefit  
Resolution 820 – Affordability and Accessibility of Treatment of Overweight and Obesity
15. *Resolution 821 – Modernizing the AMA/Specialty Society Relative Value Scale Update Committee (RUC) Processes*

Amendments and supplemental materials MUST be sent to [ReferenceCommitteeJ@gmail.com](mailto:ReferenceCommitteeJ@gmail.com). Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee J hearing.

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A Zoom webinar link is provided here: [https://zoom.us/webinar/register/WN\\_dUWNU-HxRu2Dlqq\\_B\\_SlhQ](https://zoom.us/webinar/register/WN_dUWNU-HxRu2Dlqq_B_SlhQ). This link is view-only. Testimony cannot be accepted via Zoom.

16. Resolution 818 – Amendment to AMA Policy on Health Care System Reform Proposals
17. *Resolution 819 – Amend Virtual Credit Card Policy*
18. Resolution 811 – Expanding Use of Medical Interpreters
19. Resolution 812 – Indian Health Service Improvements
20. *Resolution 815 – Long-Term Care and Support Services for Seniors*
21. Resolution 813 – Strengthening Efforts Against Horizontal & Vertical Integration
22. *Resolution 817 – Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations*
23. *Resolution 814 – Providing Parity for Medicare Facility Fees*
24. *Resolution 809 – Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion*
25. *Resolution 810 – Racial Misclassification*
26. *Resolution 816 – Reducing Barriers to Gender-Affirming Care through Improved Payment and Reimbursement*
27. Resolution 822 – Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation

Amendments and supplemental materials MUST be sent to [ReferenceCommitteeJ@gmail.com](mailto:ReferenceCommitteeJ@gmail.com). Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee J hearing.

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A Zoom webinar link is provided here: [https://zoom.us/webinar/register/WN\\_dUWNU-HxRu2Djqq\\_B\\_SlhQ](https://zoom.us/webinar/register/WN_dUWNU-HxRu2Djqq_B_SlhQ). This link is view-only. Testimony cannot be accepted via Zoom.



## **ORDER OF BUSINESS**

### **I-23 Reference Committee K**

Elisa Choi, MD, Chair

**November 11, 2023, 1:30 PM – 5:30 PM**

**National Harbor 2/3**

Livestream (via Zoom) available here: [https://zoom.us/webinar/register/WN\\_fZjhynqKRMyl6T77qftLTw](https://zoom.us/webinar/register/WN_fZjhynqKRMyl6T77qftLTw)

1. **Board of Trustees Report 5** - AMA Public Health Strategy: The Mental Health Crisis
2. **Council on Science and Public Health Report 7** - Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities
3. **Board of Trustees Report 14** - Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home
4. **Board of Trustees Report 2** - Opposing the Use of Vulnerable Incarcerated People in Response to Public
5. *\*Resolution 918 - Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals*
6. **Council on Science and Public Health Report 1** - Drug Shortages: 2023 Update
7. *\*Resolution 922 - Prescription Drug Shortages and Pharmacy Inventories*
8. **Resolution 902** - Post Market Research Trials
9. *\*Resolution 924 - Laboratory Developed Tests Proposed FDA Rule*
10. **Council on Science and Public Health Report 4** - Supporting and Funding Sobering Centers
11. **Resolution 916** - Elimination of Buprenorphine Dose Limits
12. **Council on Science and Public Health Report 6** - Marketing Guardrails for the "Over-Medicalization" of Cannabis Use
13. *\*Resolution 915 - Social Media Impact on Youth Mental Health*
14. **Resolution 904** - Universal Return-to-Play Protocols
15. **Resolution 914** - Adverse Childhood Experiences
16. **Council on Science and Public Health Report 2** - Precision Medicine and Health Equity
17. **Resolution 910** - Sickle Cell Disease Workforce
18. **Council on Science and Public Health Report 3** - HPV-Associated Cancer Prevention
19. **Resolution 909** - High Risk HPV Subtypes in Minoritized Populations
20. **Resolution 906** - Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices
21. *\*Resolution 923 - Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation*
22. *\*Resolution 908 - Sexuality and Reproductive Health Education*
23. **Resolution 921** - Addressing Disparities and Lack of Research for Endometriosis
24. **Resolution 905** - Support for Research on the Relationship Between Estrogen and Migraine
25. **Resolution 903** - Supporting Emergency Anti-Seizure Interventions
26. *\*Resolution 912 - Fragrance Regulation*
27. **Council on Science and Public Health Report 5** - Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room
28. *\*Resolution 917 - Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals*
29. *\*Resolution 919 - Lithium Battery Safety*
30. *\*Resolution 911 - Support for Research on the Nutritional and Other Impacts of Plant-Based Meat*
31. **Resolution 913** - Public Health Impacts of Industrialized Farms
32. **Resolution 901** - Silicosis from Work with Engineered Stone
33. *\*Resolution 907 - Occupational Screenings for Lung Disease*

*\* - Note: Items in italics were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.*

During the reference committee hearing, supplemental material may be sent to [RefCommK@gmail.com](mailto:RefCommK@gmail.com). Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented in on the Online Member Forum or orally to the committee. This address is only operational for the duration of the reference committee hearing.

## REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

### **BOT Report(s)**

- 01 Employed Physicians
- 10 Medical Decision-Making Autonomy of the Attending Physician
- 17\* Specialty Society Representation in the House of Delegates - Five-Year Review

### **CEJA Report(s)**

- 01 Physicians' Use of Social Media for Product Promotion and Compensation
- 02 Research Handling of De-Identified Patient Data

### **Report of the Speakers**

- 03 Report of the Election Task Force 2

### **Resolution(s)**

- 002 Support for International Aid for Reproductive Healthcare
- 004 Reconsideration of Medical Aid in Dying (MAID)
- 005 Adopting a Neutral Stance on Medical Aid in Dying
- 006 Inappropriate Use of Health Records in Criminal Proceedings
- 007 Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers
- 009 Physicians arrested for Non-Violent Crimes While Engaged in Public Protests

\* Contained in the Meeting Tote

## REFERENCE COMMITTEE B

### **BOT Report(s)**

- 06 Universal Good Samaritan Statute
- 07 Obtaining Professional Recognition for Medical Service Professionals

### **Resolution(s)**

- 201 Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care
- 202 Protecting the Health of Patients Incarcerated in For-Profit Prisons
- 203 Anti-Discrimination Protections for Housing Vouchers
- 204 Improving PrEP & PEP Access
- 205 Cannabis Product Safety
- 206 The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice
- 207 On-Site Physician Requirement for Emergency Departments
- 208 Non-Physician Practitioners Oversight and Training
- 210 Immigration Status in Medicaid and CHIP
- 213 Health Technology Accessibility for Aging Patients
- 215 A Public Health-Centered Criminal Justice System
- 216 Saving Traditional Medicare
- 217 Addressing Work Requirements for J-1 Visa Waiver Physicians
- 218 Youth Residential Treatment Program Regulation
- 219 Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)
- 220 Merit-Based Process for the Selection of all Federal Administrative Law Judges
- 222 Expansion of Remote Digital Laboratory Access Under CLIA
- 223 Initial Consultation for Clinical Trials Under Medicare Advantage
- 224 ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers
- 225 Antipsychotic Medication Use for Hospice Patients
- 226\*Delay Imminent Proposed Changes to U.S. Census Questions Regarding Disability
- 234\*Pharmacy Benefit Manager (PBM) Control of Treating Disease States

\* Contained in the Meeting Tote

## REFERENCE COMMITTEE C

### **CME Report(s)**

- 01 Leave Policies for Medical Students, Residents, Fellows, and Physicians
- 03 Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education
- 04 Recognizing Specialty Certifications for Physicians
- 05 Organizations to Represent the Interests of Resident and Fellow Physicians

### **Resolution(s)**

- 301 Clarification of AMA Policy D-310-948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure”
- 302 Medical Student Reports of Disability-Related Mistreatment
- 304 Health Insurance Options for Medical Students
- 305 Addressing Burnout and Physician Shortages for Public Health
- 306 Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies
- 307\* Re-evaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program

\* Contained in the Meeting Tote

## REFERENCE COMMITTEE F

### **BOT Report(s)**

- 12\* American Medical Association Meeting Venues and Accessibility (REVISED v2 )
- 13 House of Delegates (HOD) Modernization

### **CLRPD Report(s)**

- 01 Women Physicians Section Five-Year Review

### **HOD Comm on Compensation of the Officers**

- 01 Report of the HOD Committee on Compensation of the Officers

### **Report of the Speakers**

- 02 Extending Online Forum Trial Through A-24

### **Resolution(s)**

- 601 Carbon Pricing to Address Climate Change
- 606 Prevention of Healthcare-Related Scams

\* Contained in the Meeting Tote

## REFERENCE COMMITTEE J

### **CMS Report(s)**

- 01 ACO REACH
- 02 Health Insurers and Collection of Patient Cost-Sharing
- 03 Strengthening Network Adequacy
- 05 Medicaid Unwinding Update
- 06 Rural Hospital Payment Models
- 07 Sustainable Payment for Community Practices

### **Resolution(s)**

- 801 Improving Pharmaceutical Access and Affordability
- 802 Improving Nonprofit Hospital Charity Care Policies
- 803 Improving Medicaid and CHIP Access and Affordability
- 804 Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity
- 805 Medication Reconciliation Education
- 806 Evidence-Based Anti-Obesity Medication as a Covered Benefit
- 807 Any Willing Provider
- 808 Prosthodontic Coverage after Oncologic Reconstruction
- 809 Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion
- 811 Expanding the Use of Medical Interpreters
- 812 Indian Health Service Improvements
- 813 Strengthening Efforts Against Horizontal & Vertical Consolidation
- 814 Providing Parity for Medicare Facility Fees
- 815 Long-Term Care and Support Services for Seniors
- 817 Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations
- 818 Amendment to AMA policy on healthcare system reform proposals
- 819 Amend Virtual Credit Card Policy
- 820 Affordability and Accessibility of Treatment of Overweight and Obesity
- 821\*Modernizing the AMA/Specialty Society RVS Update Committee (RUC) Processes

\* Contained in the Meeting Tote

## REFERENCE COMMITTEE K

### **BOT Report(s)**

- 02 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies
- 05 AMA Public Health Strategy: The Mental Health Crisis
- 14 Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home

### **CSAPH Report(s)**

- 01 Drug Shortages: 2023 Update
- 02 Precision Medicine and Health Equity
- 03 HPV-Associated Cancer Prevention
- 04 Supporting and Funding Sobering Centers
- 05 Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room
- 06 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use
- 07 Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities

### **Resolution(s)**

- 901 Silicosis from Work with Engineered Stone
- 902 Post Market Research Trials
- 903 Supporting Emergency Anti-Seizure Interventions
- 904 Universal Return-to-Play Protocols
- 905 Support for Research on the Relationship Between Estrogen and Migraine
- 906 Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices
- 909 High Risk HPV Subtypes in Minoritized Populations
- 910 Sickle Cell Disease Workforce
- 913 Public Health Impacts of Industrialized Farms
- 914 Adverse Childhood Experiences
- 915 Social Media Impact on Youth Mental Health
- 916 Elimination of Buprenorphine Dose Limits
- 921 Addressing Disparities and Lack of Research for Endometriosis
- 922 Prescription Drug Shortages and Pharmacy Inventories
- 923\*Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation

\* Contained in the Meeting Tote

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-23

Subject: American Medical Association Meeting Venues and Accessibility  
(Resolution 610-A-22, Resolve 2; and Resolution 602-I-22)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

At the 2022 Annual Meeting, Resolution 610 was introduced by the Senior Physicians Section. The House of Delegates adopted three resolves, which were incorporated into Policy G-630.140, “Lodging, Meeting Venues, and Social Functions,” as sections [6] through [8], respectively. G-630.140[8] was rescinded through approval of Board of Trustees Report 18-A-23.

A fourth resolve of Resolution 610-A-22 was referred and asked that “our AMA investigate ways of allowing meaningful participation in all meetings of the AMA by members who are limited in their ability to physically attend meetings.”

At the 2022 Interim Meeting, Resolution 602, introduced by the Southeast Delegation and the American College of Radiology, was referred. Resolution 602-I-22 asked that Policy G-630.140, “Lodging, Meeting Venues, and Social Functions,” be amended by addition and deletion to read as follows:

AMA policy on lodging and accommodations includes the following:

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has regulation or ~~enacted comprehensive~~ legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA ~~not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or~~ pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.



5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.
6. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.
7. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.
8. Our AMA will report back to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize meeting participation for members and invited attendees with disabilities.

This report responds to the referred resolve of Resolution 610-A-22, and to Resolution 602-I-22 (Note: the text of Policy G-630.140 included in Resolution 602-I-22 above includes Section [8] of the policy, since that section was not rescinded until the 2023 Annual Meeting).

#### RESOLUTION 602-I-22

Policy G-630.140, especially bullets [3] and [4], constrain options for AMA meeting venues. When Section 4 was added to the policy, the AMA Office of General Counsel determined that the most expedient way to comply with the policy would be for the AMA to follow the list (hereafter the “California list”) compiled by the State of California Attorney General’s office to comply with its state law AB 1887.

The California Legislature determined that “California must take action to avoid supporting or financing discrimination against lesbian, gay, bisexual, and transgender people.” To that end, AB 1887 prohibits a state agency, department, board, or commission from requiring any state employees, officers, or members to travel to a state that has enacted a law that: (1) has the effect of voiding or repealing existing state or local protections against discrimination on the basis of sexual orientation, gender identity, or gender expression; (2) authorizes or requires discrimination against same-sex couples or their families or on the basis of sexual orientation, gender identity, or gender expression; or (3) creates an exemption to antidiscrimination laws in order to permit discrimination against same-sex couples or their families or on the basis of sexual orientation, gender identity, or gender expression. The law also prohibits California from approving a request for state-funded or state-sponsored travel to such a state.

There are, as of the time of this report’s drafting, [24 states on the California list](#) (though it will likely consist of 26 states shortly, as the California Attorney General has announced that Missouri and Nebraska will be added). At the time the AMA decided to follow the California list, many other organizations were using the list as a guide to meeting venues and organization-funded travel. However, this list’s utility has diminished over the years, as it has had unintended consequences, including for academics, researchers, and others in the DEI and LGBTQ+ communities. [Even the City of San Francisco has decided to no longer use it for travel by its employees](#). The State of California is also considering repeal of AB1887.

While Policy G-630.140 supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors, there are already very few venues that can accommodate the House (and its many associated ancillary meetings of the sections, caucuses, etc.)

1 meeting without requiring multiple hotels and a convention center. Additionally, the size of the  
2 House is increasing. There are now over 700 delegate slots, with a corresponding number of  
3 alternate delegates, though not all credential or attend the meetings. This number further limits the  
4 venues that are options for our Annual and Interim Meetings.

5  
6 Adhering to the California list diminishes the number of venues capable of hosting the Annual and  
7 Interim Meetings even further, given that more than half the nation is deemed ineligible. It also has  
8 had the effect of making it so some Medical Student Section regions cannot have a meeting within  
9 their own region.

10  
11 RESOLUTION 610-A-22, RESOLVE 2

12  
13 As noted above, Board of Trustees Report 18-A-23 responded to the following adopted resolve of  
14 Resolution 610-A-22: That our AMA report back to the HOD by no later than the 2023 Annual  
15 Meeting with a plan on how to maximize meeting participation for members and invited attendees  
16 with disabilities. BOT Report 18-A-23 covered in detail accessibility options already in place for  
17 meeting attendees with disabilities. This report thus only will discuss the referred resolve asking  
18 that our AMA investigate ways of allowing meaningful participation in all meetings of the AMA  
19 by members who are limited in their ability to physically attend meetings.

20  
21 In trying to be responsive to all participants' needs, the AMA has provided for accommodations to  
22 be made for all in attendance who have the need for assistance. Recognizing that there are those for  
23 whom an onsite accommodation may not be enough, options for virtual participation have been  
24 made available when possible. Specifically, House meetings include Online Member Forums  
25 allowing for members to comment on the items of business before the House. In addition, members  
26 and others are invited and encouraged to view sessions through live streaming of all House sessions  
27 and reference committee hearings. However, AMA meetings are not only about the content that is  
28 delivered but about the interaction with others on-site, the availability of mentorship, and in the  
29 case of the National Advocacy Conference, the opportunity to advocate for AMA priorities by  
30 visiting with Members of Congress and their staff.

31  
32 While some would suggest a hybrid model is the best option for those who are unable to attend in-  
33 person, a hybrid meeting is not a viable solution for the Annual and Interim Meetings in particular.  
34 The cost of the meetings would likely double, as the AMA would be hosting two meetings: the  
35 virtual and the in-person. Without strict registration, credentialing, and attendance protocols there  
36 would be no way to know how many people would be attending in person and how many virtually,  
37 presenting issues with credentialing and voting.

38  
39 A hybrid model would create conundrums in contracting and financing the meeting. There would  
40 likely be either not enough hotel rooms or too many that go unused, which could cause the AMA to  
41 incur a penalty for attrition. In addition, if only a few participate virtually, it would not be worth the  
42 expense to offer that option.

43  
44 A hybrid would also result in significant issues with completing the business in a timely fashion.  
45 As experienced with the virtual special meetings, business had to be strictly limited, and the time  
46 devoted to committee hearings and House sessions still exceeded that of in-person meetings.

47  
48 Thus, while meaningful participation is a laudable goal, it is not deemed to be practical for Annual  
49 and Interim Meetings at this time. The Board of Trustees and Speakers will continue to monitor  
50 future means for enhancing participation options for those who cannot attend in person.

51

1 DISCUSSION

2  
3 While myriad factors are considered when determining future meeting sites for AMA House of  
4 Delegates meetings, the primary consideration is alignment of AMA policy and availability of  
5 acceptable venues. Acceptable venues include those which meet the needs of all meeting attendees  
6 to participate with any necessary accommodations.

7  
8 Due to current policy and size constraints the AMA is limited to approximately four properties in  
9 the continental United States: Hyatt Regency Chicago in Illinois, Gaylord Chula Vista in  
10 California, Gaylord Rockies in Denver, Colorado, and Gaylord National in Maryland as options for  
11 the Annual and Interim Meetings of the HOD. These properties are compliant with the Americans  
12 with Disabilities Act and allow for in-person participation of all members of the HOD. There are  
13 properties that could accommodate the meetings in other states, but due to discriminatory or  
14 smoking policy those are eliminated from the list of possibilities.

15  
16 While state laws are a factor, other determinations should be allowed in the consideration of future  
17 meeting venues. For example, several of the properties that can hold the AMA meeting in one  
18 venue are excluded due to state laws (e.g., Florida and Texas). The parent companies of the  
19 properties may have a strong policy that prohibits the exclusions that are not provided in the state  
20 law and would therefore make the property's own policies compliant with AMA policy. Disney,  
21 for example, is generally regarded as a nondiscriminatory employer and venue, and Orlando's  
22 Swan and Dolphin is a Disney property. Nonetheless, because of recently adopted legislation, the  
23 entire state of Florida is disallowed.

24  
25 CONCLUSION

26  
27 The Association has been boxed into the proverbial corner by well-meaning policies, but whether  
28 the AMA's policies on meeting locations are having their intended effect merits consideration. No  
29 state is likely to change its policies to secure an AMA meeting, as our meetings are relatively small  
30 and carry minimal economic value. In truth, the policies are likely of no impact outside the four  
31 walls of the AMA. Changing current policy to allow locations (states, cities) would expand options  
32 for future meetings. Selection of venues will of course be sensitive to state laws and any risks that  
33 attendees would face, but not limited by state laws. It is of utmost importance to emphasize the  
34 significance of prioritizing the safety of our participants as a central element of this policy. It is  
35 also important to address the criminalization of medicine aspect, particularly in relation to  
36 reproductive health care laws following the *Dobbs* decision. This includes a thorough examination  
37 of the potential impact of these laws on medical professionals and patients, as well as the potential  
38 implications for attendees' safety and access to comprehensive healthcare services.

39  
40 In summary, however, the Board does not believe it is prudent for the AMA to be hamstrung by  
41 policies that overly constrain its abilities to contract for and hold meetings and recommends  
42 amendments to Policy G-630.140 to allow the AMA greater latitude in venue selection while  
43 retaining strong anti-discrimination policy. The Board also notes that amendment of G-630.140[3],  
44 as suggested by Resolution 602-I-22, is a reasonable change to the venue selection policy with  
45 regard to smoking.

46  
47 RECOMMENDATION

48  
49 The Board of Trustees therefore recommends that Policy G-630.140, "Lodging, Meeting Venues,  
50 and Social Functions," be amended by addition and deletion as follows in lieu of Resolution 610-  
51 A-22, Resolve 2, and Resolution 602-I-22, and the remainder of this report be filed:

AMA policy on lodging and accommodations includes the following:

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted ~~comprehensive~~ regulation or legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to ~~hold meetings and/or primarily sponsored by our AMA, in cities, counties, or states, or~~ pay member officer or employee dues in any club, restaurant, or other institution that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.
5. Our AMA will not hold meetings organized by or primarily sponsored by our AMA at venues that have exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.
6. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.
7. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.
8. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.
9. Our AMA will utilize security experts to assess the safety risk for our attendees and guests at all venues. (Modify Current HOD Policy)

Fiscal Note: No significant fiscal impact

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-I-23

Subject: Specialty Society Representation in the House of Delegates -  
Five-Year Review

Presented by: Willie Underwood, III, MD, MSc, MPH, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the  
2 House of Delegates (HOD) required to submit information and materials for the 2023 American  
3 Medical Association (AMA) Interim Meeting in compliance with the five-year review process  
4 established by the House of Delegates in Policy G-600.020, “Summary of Guidelines for  
5 Admission to the House of Delegates for Specialty Societies,” and AMA Bylaw 8.5, “Periodic  
6 Review Process.”

7  
8 Organizations are required to demonstrate continuing compliance with the guidelines established  
9 for representation in the HOD. Compliance with the five responsibilities of professional interest  
10 medical associations and national medical specialty organizations is also required as set out in  
11 AMA Bylaw 8.2, “Responsibilities of National Medical Specialty Societies and Professional  
12 Interest Medical Associations.”

13  
14 The following organizations were reviewed for the 2023 Interim Meeting:

15  
16 American Academy of Allergy, Asthma & Immunology  
17 American Academy of Ophthalmology, Inc.  
18 American Academy of Orthopaedic Surgeons  
19 American Academy of Otolaryngology—Head and Neck Surgery  
20 American Academy of Pain Medicine  
21 American Academy of Pediatrics  
22 American Academy of Physical Medicine and Rehabilitation  
23 American Association of Neurological Surgeons  
24 Society of Nuclear Medicine and Molecular Imaging

25  
26 Each organization was required to submit materials demonstrating compliance with the guidelines  
27 and requirements along with appropriate membership information. A summary of each group’s  
28 membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty  
29 society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical  
30 specialty organizations and professional medical interest associations represented in the HOD  
31 (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also  
32 attached.

33  
34 The materials submitted indicate that: the American Academy of Ophthalmology, Inc., American  
35 Academy of Orthopaedic Surgeons, American Academy of Otolaryngology—Head and Neck  
36 Surgery, American Academy of Pain Medicine, American Academy of Pediatrics, American  
37 Academy of Physical Medicine and Rehabilitation, American Association of Neurological

1 Surgeons, and Society of Nuclear Medicine and Molecular Imaging meet all guidelines and are in  
2 compliance with the five-year review requirements of specialty organizations represented in the  
3 HOD.

4  
5 The materials submitted also indicate that the American Academy of Allergy, Asthma &  
6 Immunology did not meet all guidelines and is not in compliance with the five-year review  
7 requirements of specialty organizations represented in the HOD.

8  
9 RECOMMENDATIONS

10  
11 The Board of Trustees recommends that the following be adopted, and the remainder of this report  
12 be filed:

- 13  
14 1. The American Academy of Ophthalmology, Inc., American Academy of Orthopaedic  
15 Surgeons, American Academy of Otolaryngology—Head and Neck Surgery, American  
16 Academy of Pain Medicine, American Academy of Pediatrics, American Academy of  
17 Physical Medicine and Rehabilitation, American Association of Neurological Surgeons,  
18 and Society of Nuclear Medicine and Molecular Imaging retain representation in the  
19 American Medical Association House of Delegates. (Directive to Take Action)  
20  
21 2. Having failed to meet the requirements for continued representation in the AMA House of  
22 Delegates as set forth in AMA Bylaw B-8.5 the American Academy of Allergy, Asthma &  
23 Immunology be placed on probation and be given one year to work with AMA membership  
24 staff to increase their AMA membership. (Directive to Take Action)

Fiscal Note: Less than \$500

## APPENDIX

### *Exhibit A - Summary Membership Information*

<b>Organization</b>	<b>AMA Membership of Organization's Total Eligible Membership</b>
American Academy Allergy, Asthma & Immunology	309 of 1,592 (19%)
American Academy Ophthalmology, Inc.	3,058 of 18,390 (17%)
American Academy of Orthopaedic Surgeons	3,461 of 24,501 (14%)
American Academy of Otolaryngology—Head and Neck Surgery	2,600 of 10,430 (25%)
American Academy of Pain Medicine	154 of 564 (27%)
American Academy of Pediatrics	4,020 of 37,576 (11%)
American Academy of Physical Medicine and Rehabilitation	1,731 of 7,981 (22%)
American Association of Neurological Surgeons	689 of 3,437 (20%)
Society of Nuclear Medicine and Molecular Imaging	302 of 1,444 (21%)

***Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)***

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
  - (a) represent a field of medicine that has recognized scientific validity;
  - (b) not have board certification as its primary focus; and
  - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
  - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
  - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
  - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those physician members who are current in payment of applicable dues, and eligible to serve on committees or the governing body.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.



***Exhibit C***

**8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations.** Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

- 8.2.1** To cooperate with the AMA in increasing its AMA membership.
- 8.2.2** To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3** To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4** To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5** To provide information and data to the AMA when requested.

***Exhibit D – AMA Bylaws on Specialty Society Periodic Review***

**8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates**

**8.5 Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

**8.5.1** If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

**8.5.2** If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

**8.5.3** Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

**8.5.3.1** If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

**8.5.3.2** If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

**8.5.3.2.1** The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

**8.5.3.2.2** The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226  
(I-23)

Introduced by: American Association of Neuromuscular and Electrodiagnostic Medicine  
(AANEM), American Academy of Physical Medicine and Rehabilitation  
(AAPM&R)

Subject: Delay Imminent Proposed Changes to U.S. Census Questions Regarding  
Disability

Referred to: Reference Committee B

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1 Whereas, the National Advisory Committee of the U.S. Census Bureau is meeting November  
2 16-17, 2023, and  
3

4 Whereas, one agenda item is “Disability Collection Efforts for the Disability Community” which  
5 includes proposed changes to the disability questions currently used in the census<sup>1</sup>; and  
6

7 Whereas, there is a proposed switch from the six disability questions used in the American  
8 Community Survey (ACS) to the Washington Group Short Set (WGSS); and  
9

10 Whereas, there is evidence that the WGSS underperforms in documenting individuals with  
11 disabilities when compared to ACS <sup>2</sup>; and  
12

13 Whereas, this change has progressed without the input of the disability community and key  
14 stakeholders; and  
15

16 Whereas, language presented to the Census Scientific Advisory Committee (CSAC) on  
17 September 21, 2023 stated “*Does the Committee have recommendations regarding how to*  
18 *engage key stakeholders to help communicate with data users about the upcoming change to*  
19 *the ACS disability question set?*” and the only response was that the “*change and likely*  
20 *consequences be communicated widely to stakeholder groups*” after the change is made; and  
21

22 Whereas, the U.S. Census Bureau announced a 60-day comment period on the proposed  
23 changes to the disability questions in the Federal Register on October 20,2023; therefore be it  
24

25 RESOLVED, that our American Medical Association urge that the National Advisory Committee  
26 of the U.S. Census Bureau, that is meeting on November 16-17, 2023, delay a decision on the  
27 change in the U.S. Census disability questions until comprehensive input has been obtained  
28 from the disability community and key stakeholders (Directive to Take Action); and be it further  
29

30 RESOLVED, that our AMA submit comments before the December 19,2023 deadline to the U.S  
31 Census Bureau regarding the changes proposed in the Federal Register to the disability  
32 questions in the census (Directive to Take Action); and be it further  
33

34 RESOLVED, that our AMA request that the U.S. Census Bureau develop an extensive plan to  
35 improve the inclusion of individuals with disabilities across the activities of the U.S. Census  
36 Bureau (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA encourage the formation of a U.S. Government task force to develop
- 2 a plan for improving and expanding disability data collection across the federal government.
- 3 (New HOD Policy)
- 4

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 11/4/2023

#### REFERENCES

1. National Advisory Committee Fall Meeting: November 16-17, 2023 (2023) <https://www.census.gov>. Available at: <https://www.census.gov/about/cac/nac/meetings/2023-11-meeting.html> (Accessed: 02 November 2023).
2. Lauer, E.A., Henly, M. and Coleman, R. (2018) 'Comparing estimates of disability prevalence using federal and international disability measures in National Surveillance', *Disability and Health Journal*, 12(2), pp. 195-202. doi:10.1016/j.dhjo.2018.08.008.
3. Census Bureau, Department of Commerce, " Agency Information Collection Activities; Submission to the Office of Management and Budget (OMB) for Review and Approval; Comment Request American Community Survey and Puerto Rico Community Survey." *Federal Register* 88, FR 72424, PG 72424-72427. October 20, 2023.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234  
(I-23)

Introduced by: Private Practice Physician Section

Subject: Pharmacy Benefit Manager (PBM) Control of Treating Disease States

Referred to: Reference Committee B

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Whereas, In October 2023, prescribers of anti-obesity medications were alerted by CVS's pharmacy benefit manager (PBM) that their patients may no longer be able to get their prescribed anti-obesity medications using prescriptions from their physician or prescriber but would instead need to enroll in the CVS "Weight Management Program" to have a prescriber in that program prescribe the medication; and

Whereas, These policies are going in to place November 1, 2023; and

Whereas, This appears to be an unprecedented example of patients being required to get medical services including prescriptions from a specific prescriber that is contracted with the pharmacy benefit manager directly; and

Whereas, A prescriber contracted with the PBM is less likely to have the patients' best interest when choosing a medication; and

Whereas, This will allow the PBM to limit access to this effective but expensive class of medications; and

Whereas, The American Medical Association recognized obesity as a disease; and

Whereas, There are currently more than 6,000 physicians that are obesity specialists as Diplomates of the American Board of Obesity Medicine; and

Whereas, This will have a significant impact on obesity physicians' practices as the PBM is diverting patients from their physicians' office to the PBM's program; and

Whereas, Patients with obesity deserve comprehensive care from the physician or prescriber of their choice; and

Whereas, This is a threat to all physician specialties if this action is allowed to continue; who knows which disease state could be next; therefore be it

Resolved, That our American Medical Association take a strong public stance against allowing payors and pharmacy benefit managers to divert patients to their own care teams for medical care and medication prescribing (New HOD Policy); and be it further

Resolved, That our AMA take immediate action (which may include legal or policy action) to assess and pursue appropriate measures designed to prevent payors and pharmacy benefit managers from diverting patients to their own care teams for medical care and medication prescribing (Directive to Take Action).

Fiscal Note: Modest – Between \$1,000 and \$5,000  
Received: 11/10/23

References:

1. <https://www.abom.org/abom-adds-more-than-950/>
2. Angela Fitch, et al. "Comprehensive care for patients with obesity: An Obesity Medicine Association Position Statement" Obesity Pillars, Volume 7, 2023.

## RELEVANT AMA POLICY

### Recognition of Obesity as a Disease H-440.842

Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

Citation: Res. 420, A-13; Reaffirmed: CSAPH Rep. 08, A-23

### Addressing Adult and Pediatric Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
  - Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
  - Advocacy efforts at the state and federal level to impact the disease obesity.
  - Health disparities, stigma and bias affecting people with obesity.
  - Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
  - Increasing obesity rates in children, adolescents and adults.
  - Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods

and food marketing practices.

6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.

7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5. above.

Citation: BOT Rep. 11, I-06; Reaffirmed: A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18; BOT Action in response to referred for decision: Res. 415, A-22; Modified: Res. 818, I-22



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307  
(I-23)

Introduced by: Idaho

Subject: Re-evaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program

Referred to: Reference Committee C

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1 Whereas, the National Health Service Corps (NHSC) Loan Repayment Program plays a crucial  
2 role in addressing the shortage of healthcare providers in rural and underserved areas across  
3 the United States, utilizing a scoring system to allocate loan repayment opportunities to eligible  
4 physicians, which includes factors such as Health Professional Shortage Area (HPSA) scores,  
5 community need, and other relevant criteria; and  
6

7 Whereas, rural communities often face significant and unique challenges in attracting and  
8 retaining healthcare professionals, exacerbating the healthcare disparities experienced by these  
9 populations; and  
10

11 Whereas, the current scoring system utilized by the NHSC has produced disparities among  
12 states with the lowest physicians per capita receiving incongruent scores; and  
13

14 Whereas, it is imperative to ensure that the scoring criteria used by the NHSC appropriately  
15 capture the needs of rural and underserved communities, accurately reflecting the shortage of  
16 healthcare providers and the various challenges faced by these regions in recruiting and  
17 retaining physicians; therefore be it  
18

19 RESOLVED, that our American Medical Association advocate, in partnership with other major  
20 medical associations at the federal level, for a comprehensive reevaluation and assessment of  
21 the effectiveness and equity of the Health Professional Shortage Area scoring criteria employed  
22 by the National Health Service Corps Loan Repayment Program with appropriate revisions to  
23 meet the physician workforce needs for the neediest rural communities and underserved areas.  
24 (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 10/19/2023

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 821  
(I-23)

Introduced by: American College of Physicians, American Academy of Family Physicians,  
Florida Medical Association

Subject: Modernizing the AMA/Specialty Society RVS Update Committee (RUC)  
Processes

Referred to: Reference Committee J

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Whereas, the American Medical Association/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) plays a pivotal role in determining the relative values of healthcare services, which in turn influences payment rates, resource allocation, and the overall healthcare landscape; and

Whereas, the Centers for Medicare and Medicaid Services included a request for comment in its proposed 2024 Medicare Physician Fee Schedule rule, asking for comments on evaluating Evaluation and Management Services more regularly and comprehensively; and

Whereas, the healthcare industry is evolving rapidly with advancements in medical technology, changes in care delivery models, and a growing emphasis on value-based care, necessitating a more dynamic and evidence-based approach to relative value determinations; and

Whereas, current RUC processes primarily rely on expert opinions and surveys of physicians and other healthcare professionals, which may not fully capture the diverse and nuanced factors that affect the value of healthcare services; and

Whereas, leveraging metadata, evidence-based data, and modern data analytics tools may provide a more accurate, comprehensive, and transparent basis for relative value determinations; and

Whereas, modernizing RUC processes to incorporate evidence-based data and metadata can enhance the accuracy and relevance of payment rates, leading to more equitable compensation for healthcare services and improved patient outcomes; and

Whereas, the use of evidence-based data can also promote equity in healthcare by accounting for variations in patient populations, geographical regions, and healthcare settings; and

Whereas, patient access to care and physicians would benefit from a clear timeline for the implementation of steps to modernize RUC processes; therefore be it

RESOLVED, that our American Medical Association encourage the AMA/Specialty Society RVS Update Committee (RUC) to modernize the RUC's processes and implement the following principles:

1. Data-Driven Decision Making: Enhance the data used in making recommendations by shifting from almost exclusive reliance on surveys of physicians and others who perform services to

broader use of evidence-based data and metadata (e.g., procedure time from operating logs, hospital length of stay data, and other extant data sources) that permit assessment of resource use and the relative value of physician and other qualified healthcare professional services comprehensively. This can ensure that data is reliable, verifiable, and can be accurately compared to or integrated with other important databases.

2. Collaboration and Transparency: Seek collaboration with healthcare data experts, stakeholders, and relevant organizations to maintain transparent data collection and analysis methodologies.

3. Continuous Review and Adaptation: Expand and enhance its system for continuous review and adaptation of relative value determinations beyond its Relativity Assessment Workgroup and other current strategies (e.g., New Technology/New Services list) to stay aligned with evolving healthcare practices and technologies.

4. Equity and Access: Work with the Current Procedural Terminology Editorial Panel and others, as appropriate, to identify the impact that factors related to healthcare equity and access have on the resources used to provide the services of physicians and other qualified healthcare professionals and how to account for those resources in the description and subsequent valuation of those services.

5. Broader Engagement: Actively engage with other parties to gather input and ensure that relative value determinations align with the broader healthcare community's goals and values.

6. Education and Training: Invest in the education and training of its members, AMA and specialty society staff, and other participants (e.g., specialty society RUC advisors) to build expertise in evidence-based data analysis and metadata utilization.

7. Timely Implementation: Invest the necessary resources and establish a clear timeline for the implementation of these modernization efforts, with regular progress self-assessments and adjustments as needed (Directive to Take Action); and be it further

RESOLVED, that our AMA provide an informational report back to the House of Delegates at the 2025 annual meeting on the RUC process and modernizations efforts. (Directive to take Action)

Fiscal Note: \$4.4 million: Professional fees for data collection and the hiring of two new senior professional staff.

Received: 10/10/23

## RELEVANT AMA POLICY

### H-400.969 RVS Updating

Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers

new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC); and (5) supports the ongoing effort of members of the federation to analyze the valuation of CPT codes describing similar services by gender to ensure equitable valuation. [BOT Rep. O, I-92 Reaffirmed by BOT Rep. 8 - I-94 Reaffirmed by BOT Rep. 7, A-98 Reaffirmed: CMS Rep. 12, A-99 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmation I-10 Appended: Res. 822, I-12 Reaffirmation I-13 Reaffirmed: Sub. Res. 104, A-14 Reaffirmed in lieu of Res. 216, I-14 Reaffirmation A-15 Appended: Res. 105, A-23]

#### **H-400.959 Refining and Updating the Physician Work Component of the RBRVS**

The AMA: (1) supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop pediatric-specific CPT codes and physician work relative value units to incorporate children's services into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues to object to use of the relative values as a mechanism to preserve budget neutrality. [BOT Rep. I-93-26 Reaffirmed by BOT Rep. 8 - I-94 Res. 806, I-94 Reaffirmed: Sub. Res. 816, I-99 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15]

#### **H-400.956 RBRVS Development**

(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review;  
(2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies;  
(3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work;  
(4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and  
(5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians. [BOT Rep. 16, A-95 BOT Rep. 11, A-96 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15]

#### **D-400.986 The RUC: Recent Activities to Improve the Valuation of Primary Care Services**

Our AMA continues to advocate for the adoption of AMA/Specialty Society RVS Update Committee (RUC) recommendations, and separate payment for physician services that do not necessarily require face-to-face interaction with a patient. [BOT Rep. 14, A-08 Reaffirmed: CMS Rep. 01, A-18]

#### **H-70.980 Bundling CPT Codes**

1. Our AMA, through its CPT Editorial Panel and Advisory Committee, will continue to work with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies.  
2. Our AMA strongly urges the Centers for Medicare & Medicaid Services (CMS) to not treat bundling of existing services into a common code as a new procedure and new code.  
3. Our AMA will advocate for a phase-in of new values for codes where the cuts resulting from the identification of misvalued services cause a significant reduction from the value of the existing codes and work with CMS to achieve a smooth transition for such codes.  
4. The RUC will take into consideration CMS's willingness or reluctance to transition large payment reductions as it schedules the review of relative values for bundled services or other codes that come before the RUC as a result of the identification of potentially misvalued services.  
5. Our AMA strongly supports RUC recommendations and any cuts by CMS beyond the RUC recommendations will be strongly opposed by our AMA. [Sub. Res. 801, I-91 Reaffirmed: Res. 814, A-

00Reaffirmed: CMS Rep. 6, A-10Appended: Res. 118, A-10Reaffirmation I-13, Reaffirmed: CMS Rep. 01, A-23]

**H-400.962 The AMA/Specialty Society RVS Update Process**

Our AMA will strengthen its efforts to secure CMS adoption of the AMA/Specialty Society RVS Update Committee's (RUC) recommendations. [BOT Rep. N, A-93Reaffirmed: Sub. Res. 821, I-99Reaffirmed: BOT Rep. 14, A-08Reaffirmed: CMS Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 923  
(I-23)

Introduced by: American Society for Reproductive Medicine

Subject: Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation

Referred to: Reference Committee K

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1 Whereas, current FDA regulations prohibit anonymous sperm donors from among men who  
2 have had sex with men (MSM) in the past five years;<sup>1</sup> and  
3

4 Whereas, the FDA ban on men who have sex with men has been in place since 2005, and is  
5 based on data during the HIV epidemic in the 1980s and 1990s;<sup>1</sup> and  
6

7 Whereas, donor sperm is quarantined for six months and the sperm donors are subsequently  
8 re-tested for HIV prior to releasing donor sperm for use in fertility procedures, making this ban  
9 archaic, outdated, and obsolete; and  
10

11 Whereas, the FDA has recently eliminated its eligibility criteria for blood donation based on  
12 sexual orientation;<sup>2,3,4</sup> and  
13

14 Whereas, there is a significant shortage of diverse sperm donors among certain racial/ethnic  
15 groups;<sup>5</sup> and  
16

17 Whereas, in an Ethics Committee Opinion,<sup>6</sup> the American Society for Reproductive Medicine  
18 (ASRM) states that “ethical arguments supporting denial of access to fertility services on the  
19 basis of marital or sexual orientation cannot be justified;” and  
20

21 Whereas, there is no restriction on oocyte donors based on sexual orientation; and  
22

23 Whereas, there is no clinical reason to ban prospective sperm donors from among men who  
24 have had sex with men in the past five years; therefore be it  
25

26 RESOLVED, that our American Medical Association work with other interested organizations to  
27 ask the US Food and Drug Administration (FDA) to eliminate its eligibility criteria for sperm  
28 donation based on sexual orientation, with a report back at I-24. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/17/23

## REFERENCES

1. Why gay men and other groups are banned from donating sperm - The Washington Post at <https://www.washingtonpost.com/business/2022/10/20/sperm-donor-criteria/>
2. Red Cross Statement on FDA's Final Guidance Regarding Individual Donor Assessment for Blood Donation, at [https://www.redcross.org/about-us/news-and-events/press-release/2020/statement-on-updated-fda-donor-eligibility-criteria.html?adobe\\_mc=MC MID%3D57531929431274495871558106654427509693%7CMCORGID%3D723A22C757518E2C7F000101%2540AdobeOrg%7CTS%3D1696685365](https://www.redcross.org/about-us/news-and-events/press-release/2020/statement-on-updated-fda-donor-eligibility-criteria.html?adobe_mc=MC MID%3D57531929431274495871558106654427509693%7CMCORGID%3D723A22C757518E2C7F000101%2540AdobeOrg%7CTS%3D1696685365)
3. Blood Donation Eligibility for LGBTQ | Red Cross Blood Services at <https://www.redcrossblood.org/donate-blood/how-to-donate/eligibility-requirements/lgbtq-donors.html>
4. Red Cross implements end to blood donor restrictions on gay, bisexual men (axios.com), at <https://www.axios.com/2023/08/07/new-rules-blood-donation-gay-men>
5. "Diverse sperm shortage causes dilemma for some Black women: Have a baby who doesn't share your background or remain childless, at <https://www.cbsnews.com/amp/news/nationwide-shortage-diverse-sperm-donors-cryobank/>; 4/12/23, accessed 10/10/23
6. "Access to fertility treatment by gays, lesbians, and unmarried persons: a committee opinion. Ethics Committee of the American Society for Reproductive Medicine. Fertil Steril 2013; 100: 1524-7.

## RELEVANT AMA POLICY

### Blood and Tissue Donor Deferral Criteria H-50.973

Our AMA: (1) supports the use of rational, scientifically-based deferral periods for donation of blood, corneas, and other tissues that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; (4) supports research into individual risk assessment criteria for blood and tissue donation; and (5) will continue to lobby the United States Food and Drug Administration to use modern medical knowledge to revise its decades-old deferral criteria for MSM (men who have sex with men) donors of corneas and other tissues.

### Blood Shortage and Collection H-50.990

In response to a continuing need for blood for transfusion and decreasing supplies of allogeneic blood, our AMA supports programs that encourage donation of blood to the allogeneic supply by health volunteer donors; and the AMA encourages physicians to participate in promotional efforts to encourage blood donation, and urges the American Blood Commission to actively participate in these programs.

### Blood Donor Recruitment D-50.998

1. Our AMA shall encourage the Food and Drug Administration to continue evaluating and monitoring regulations on blood donation and to consider modifications to the current exclusion policies if sufficient scientific evidence supports such changes.
2. Our AMA encourages the U.S. Food and Drug Administration to engage in dialogue with the American Association of Blood Banks and relevant stakeholders to reanalyze their therapeutic phlebotomy policies on variances, including but not limited to hereditary hemochromatosis.

### Voluntary Donations of Blood and Blood Banking H-50.995

Our AMA reaffirms its policy on voluntary blood donations (C-63); and directs attention to the need for adequate donor selection and post-transfusion follow-up procedures. Our AMA (1) endorses the FDA's existing blood policy as the best approach to assure the safety and adequacy of the nation's blood supply; (2) supports current federal regulations and legislation governing the safety of all blood and blood products provided they are based on sound science; (3) encourages the FDA to continue aggressive surveillance and inspection of foreign establishments seeking or possessing United States licensure for the importation of blood and blood products into the United States; and (4) urges regulatory agencies and collection agencies to balance the implementation of new safety efforts with the need to maintain adequate quantities of blood to meet transfusion needs in this country.

**Support of Human Rights and Freedom H-65.965**

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

**Sexual Orientation and/or Gender Identity as an Exclusionary Criterion for Youth Organization H-65.979**

Our AMA asks youth oriented organizations to reconsider exclusionary policies that are based on sexual orientation or gender identity.

**1.1.2 Prospective Patients**

As professionals dedicated to protecting the well-being of patients, physicians have an ethical obligation to provide care in cases of medical emergency. Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care. Nor may physicians decline a patient based solely on the individual's infectious disease status. Physicians should not decline patients for whom they have accepted a contractual obligation to provide care.

However, physicians are not ethically required to accept all prospective patients. Physicians should be thoughtful in exercising their right to choose whom to serve.

A physician may decline to establish a patient-physician relationship with a prospective patient, or provide specific care to an existing patient, in certain limited circumstances:

- (a) The patient requests care that is beyond the physician's competence or scope of practice; is known to be scientifically invalid, has no medical indication, or cannot reasonably be expected to achieve the intended clinical benefit; or is incompatible with the physician's deeply held personal, religious, or moral beliefs in keeping with ethics guidance on exercise of conscience.
- (b) The physician lacks the resources needed to provide safe, competent, respectful care for the individual. Physicians may not decline to accept a patient for reasons that would constitute discrimination against a class or category of patients
- (c) Meeting the medical needs of the prospective patient could seriously compromise the physician's ability to provide the care needed by his or her other patients. The greater the prospective patient's medical need, however, the stronger is the physician's obligation to provide care, in keeping with the professional obligation to promote access to care.
- (d) The individual is abusive or threatens the physician, staff, or other patients, unless the physician is legally required to provide emergency medical care. Physicians should be aware of the possibility that an underlying medical condition may contribute to this behavior.

AMA Principles of Medical Ethics: I,VI,VIII,X

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

**Nondiscrimination Policy H-65.983**

The AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity.

**Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976**

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

**8.5 Disparities in Health Care**



Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
- (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
- (e) Encourage shared decision making.
- (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

- (g) Help increase awareness of health care disparities.
- (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
- (i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

AMA Principles of Medical Ethics: I,IV,VII,VIII,IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

### **Safety of Blood Donations and Transfusions H-50.975**

Our AMA:

- (1) Supports working with blood banking organizations to educate prospective donors about the safety of blood donation and blood transfusion;
- (2) Supports the use of its publications to help physicians inform patients that donating blood does not expose the donor to the risk of HIV/AIDS;
- (3) Encourages physicians to inform high-risk patients of the value of self-deferral from blood and blood product donations; and
- (4) Supports providing educational information to physicians on alternatives to transfusion

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227  
(I-23)

Introduced by: Private Practice Physicians Section

Subject: Reforming Stark Law's Blanket Self-Referral Ban

Referred to: Reference Committee B

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1 Whereas, Current Stark law imposes inconsistent restrictions on physicians self-referral without  
2 placing any limitations on hospital system self-referral practices with many health systems  
3 requiring self-referral while physicians who self-refer face thousands of dollars in fines,  
4 exclusion from Medicare and Medicaid, and possible jail time, thereby creating an unfair  
5 competitive landscape within the healthcare industry<sup>(1,2)</sup>; and  
6

7 Whereas, The unequal restriction on self-referral has contributed to a trend of consolidation and  
8 vertical integration—including hospitals' and payers' acquisition of clinics, ambulatory surgery  
9 centers (ASCs), and similar entities—exacerbating rising healthcare costs while degrading the  
10 quality of patient care<sup>(3-5)</sup>; and  
11

12 Whereas, For the optimal performance of integrated care delivery platforms to be both high-  
13 quality and cost-effective while at the same time patient-centered depends on the alignment of  
14 incentives for physicians and would require physicians have the opportunity to compete with  
15 health systems and payer-providers; however, current Stark law effectively prohibits physicians  
16 from competing with these vertically integrated healthcare entities in the delivery of integrated  
17 care to our patients, further demonstrating the need to balance the benefits of integration with  
18 the importance of preserving a fair and competitive environment for physicians; and  
19

20 Whereas, The prohibition of self-referral perpetuates challenges that can hinder patient access  
21 to care by shifting the burden of quality assessment onto patients who may lack the necessary  
22 information to make informed decisions<sup>6</sup>; and  
23

24 Whereas, The restriction on self-referral for Medicare and Medicaid patients may compel  
25 physicians to refer patients to providers without sufficient knowledge of their particular quality or  
26 capabilities, impacting patient outcomes; and  
27

28 Whereas, The current self-referral prohibition impedes the implementation of capitated, risk-  
29 adjusted payment models within healthcare delivery, limiting the ability to explore innovative  
30 care arrangements that prioritize cost-effective and patient-centered care; and  
31

32 Whereas, Our American Medical Association has a responsibility to investigate issues that  
33 impact physicians and their patients; therefore be it  
34

35 Resolved, That our American Medical Association recognizes the substantial impact of the Stark  
36 law's unequal restrictions on independent physicians, contributing to the growing trend of  
37 hospital consolidation, which has led to negative consequences of restricted access to care and  
38 inflated costs (New HOD Policy); and be it further

39 Resolved, That our American Medical Association supports comprehensive Stark law reform  
40 aimed at rectifying the disparities by ending the blanket ban on self-referral practices,

- 1 particularly in the context of capitated, risk-adjusted payment programs such as Medicare  
 2 Advantage and Medicaid managed care (Directive to Take Action); and be it further  
 3  
 4 Resolved, That our American Medical Association is committed to advocating for equitable and  
 5 balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates  
 6 the delivery of high-quality, patient-centered care (New HOD Policy).

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 11/10/23

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## **RELEVANT AMA POLICY**

### **Stark Law and Physician Compensation H-385.914**

Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.

Citation: BOT Rep. 6, I-15

### **Physicians' Involvement in Commercial Ventures H-140.984**

Our AMA opposes an across-the-board ban on self-referrals because of benefits to patients including increased access and competition, but proposes a list of standards to ensure ethical and acceptable financial arrangements:

- (1) Opportunity to Invest - The opportunity to invest in the medical or health care facility established by a health care service(s) (HCS) financial arrangement should be open to all individuals who are financially able and interested in the investment. This would include non-physicians. The only exception allowed would be for a sole community health care provider where ownership could be limited to potential referring physicians or their immediate family due to a lack of other individuals who have sufficient capital and interest to establish the facility.
- (2) Real Investment at Risk - Each investor should be undertaking a real financial risk similar to that which might occur in any other similar commercial investment. A referring physician should not be allowed to become involved in the HCS investment without incurring a real financial risk. The ability of a physician to refer patients must not be considered "capital" to become an investor in the facility. Each investor in the medical facility must be at risk by virtue of a binding commitment to capitalize the venture, such as a commitment to contribute money, property or services.
- (3) Patient Referral Requirement - No investor in the medical facility can be required or coerced in any manner to refer patients to the facility. No investor can be required to divest his or her investment for failure to refer patients. No investor can be required to divest because he or she moves from the area or ceases practicing medicine.
- (4) Distribution of Profit or Equity - Distribution should be based generally on the amount contributed to capital. Remuneration or profit distribution may not be related to patient referrals.
- (5) Disclosure of Ownership Interest - A physician or other health care professional or provider with an ownership interest in a medical or other health care facility or service to which the physician refers patients must disclose to the patients this ownership interest. A general disclosure can be made in a manner which is appropriate to his or her practice situation.
- (6) Request for Care - Each patient of a physician with an ownership interest (or whose immediate family member has an interest) must be provided with a physician's request for ancillary care to enable the patient to select a facility for such care. However, in accordance with the physician's ethical responsibility to provide the best care for the patient, the physician must be free to recommend what in the physician's judgment is the most appropriate facility, including his or her own facility.
- (7) Notification of Ownership Interest to Payer - If the physician (or immediate family member) has an ownership interest in a medical or health care facility or service to which he or she refers patients who are Medicare beneficiaries, this physician should identify the ownership interest on the Medicare claim form. If the Medicare carrier detects a pattern suggesting inappropriate utilization, the matter could be referred to the PRO for follow-up pursuant to the existing PRO

review process. Such PRO review would have to be conducted in a uniformly fair, open-minded manner.

(8) Internal Utilization Review Program - Each medical facility with referring physician owners (or immediate family members) must have an internal utilization review program to monitor referrals by such physicians. Regular reports from this internal program should be made available to the Medicare carrier on request.

(9) Compliance with Standards - Failure to comply with any one individual standard or compliance with all the standards, in and of itself, would not be sufficient to find that the arrangement is illegal. The entire arrangement needs to be examined to determine whether it is merely a sham arrangement to conceal a kickback scheme or whether it is "legal." Failure to comply with standards would subject the HCS investment arrangement to further scrutiny.

Citation: BOT Rep. ZZ, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 201, I-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmation A-09; Reaffirmed: Res. 239, A-12; Reaffirmation A-15; [Reaffirmed: CMS Rep. 05, A-17](#)

## **Health Care Entity Consolidation D-383.980**

Our AMA adopts the following Accountable Care Organization (ACO) principles:

1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.

2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first.

A. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.

B. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.

C. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.

D. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.

3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.

4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.

5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.

6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

A. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.

B. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.

C. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.

D. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

E. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures.

Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.

8. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.

9. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.

10. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.

11. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.

12. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.

13. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

Citation: Res. 819, I-10; Reaffirmation A-11; Reaffirmed: Res. 215, A-11; Reaffirmation: I-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: Sub. Res. 711, A-15; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmation: I-17; Reaffirmation: A-19; Reaffirmation: A-23

### **9.6.9 Physician Self-Referral**

Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first.

When physicians enter into arrangements that provide opportunities for self-referral they must:

(a) Ensure that referrals are based on objective, medically relevant criteria.

(b) Ensure that the arrangement:

(i) is structured to enhance access to appropriate, high quality health care services or products; and

(ii) within the constraints of applicable law:

a. does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;

b. does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and

c. adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.

(c) Take steps to mitigate conflicts of interest, including:

(i) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;

(ii) establishing mechanisms for utilization review to monitor referral practices; and

(iii) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.

(d) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

Citation: CEJA Rep. 1, I-08; Reaffirmation A-15

### **Physician Ownership and Referral for Imaging Services D-270.995**

Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.

Citation: Res. 235, A-04; Reaffirmed in lieu of Res. 901, I-05; Reaffirmed: BOT Rep. 10, A-15; Reaffirmed in lieu of Res. 213, A-15



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228  
(I-23)

Introduced by: Organized Medical Staff Section

Subject: The Employee Retirement Income Security Act (ERISA) of 1974 Revisited

Referred to: Reference Committee B

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1 Whereas, The Employee Retirement Income Security Act (ERISA) of 1974 was initially intended  
2 as a protection for workers' pension plans with employer-based health plans a secondary late  
3 add-on; and  
4

5 Whereas, When ERISA was first implemented, a very low percentage of the population was  
6 covered by employer-based health plans, but today employer-based health insurance is the  
7 single largest segment of the U.S. health insurance market<sup>1</sup>; and  
8

9 Whereas, The provisions of ERISA protect the majority of employer-based health care plans  
10 from state level regulation and legal proceedings at the state level<sup>(1,2)</sup>; and  
11

12 Whereas, Although ERISA requires plans to establish a grievance and appeals process for  
13 participants to get benefits from their plans and gives participants the right to sue for benefits  
14 and breaches of fiduciary duty, contending against care decisions under employer-based health  
15 plans has such severe restrictions in the scope and penalties for mismanaged care in retrospect  
16 that most attorneys are not qualified to take on such cases<sup>(3,4)</sup>; and  
17

18 Whereas, Actions against ERISA-protected employer-based health care plans cannot be  
19 brought in state courts but must be brought in special federal courts<sup>5</sup>; and  
20

21 Whereas, ERISA-protected plans may only be sued for actual monetary damages and not pain  
22 or suffering, nor loss of wages etc.<sup>5</sup>; and  
23

24 Whereas, After initial filing against an ERISA-protected plan, new information is not admissible  
25 going forward<sup>5</sup>; and  
26

27 Whereas, In the past, suits against ERISA-protected plans largely failed, with one such decision  
28 at the United States Supreme Court evoking a dissenting opinion by Justice Ruth Bader  
29 Ginsberg, who stated that this was an unfair law and a bad law because it restricts individual  
30 rights excessively and should be replaced by a better law, states, many attorneys and even the  
31 AMA shied away from attempting to eliminate or change ERISA; and  
32

33 Whereas, Justice Ginsberg said ERISA is a "candidate for the most inscrutable legislation  
34 Congress ever passed" in a 2004 Supreme Court case that held that negligence claims against  
35 employer-sponsored health plans are preempted by ERISA, suggesting that congressional  
36 action amending ERISA may be the only mechanism available to provide patients with adequate  
37 compensation for damages incurred as a result of coverage decisions made by employer-  
38 sponsored health plans<sup>(6,7)</sup>; and  
39

Whereas, In December 2020, *Rutledge v. PCMA* determined that ERISA does not prevent states from enacting laws regulating the abuse of payment practices of pharmacy benefit managers (PBMs), the middlemen that manage prescription drug benefits for health insurers, Medicare Part D drug plans, and large employers. The suit was brought by the Attorney General of Arkansas defending a state law in that regard and, among others, the American Medical Association filed an amicus curae brief. The Court rejected the argument that ERISA made simple enforcement mechanism “impermissible” because PBMs administered benefits on behalf of ERISA plans. Justice Sotomayor explained however that the enforcement mechanisms “do not require ERISA plan administrators to structure their benefit plans in any particular manner, nor do they lead to anything more than potential operational inefficiencies” of PBMs<sup>8</sup>; and

Whereas, There is now an argument that may weaken the total protection ERISA plans have had in the state arena, and if so, may open ERISA plans to more substantive scrutiny at the state level that could lead to limiting abuses of some of those plans, improving healthcare and patient rights; and

Whereas, the prevailing tide in some federal legislative circles is that the federal government should leave more jurisdiction to the states, leaving open the possibility that ERISA itself could be substantially amended at this time; therefore be it

Resolved, That our American Medical Association study the implication of the Supreme Court decision in *Rutledge v. PCMA*, and any other relevant legal decisions of the last several years, as well as the contemporary political temperament, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 when the quality of care or healthcare outcomes are questioned, reporting back to the House of Delegates by I-24 (Directive to Take Action).

Fiscal Note: Moderate – between \$5,000 and \$10,000

Received: 11/10/23

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8. One Pager on Unanimous Decision Reversing Eighth Circuit; National Center for Policy Analysis; <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiLzbjnrtaBAxWdEVkFHRZ8AkgQFnoECBUQAQ&url=https%3A%2F%2Fncpa.org%2Fsites%2Fdefault%2Ffiles%2F2020-12%2Fncpa-one-pager-unanimous-decision-reversing-eighth-circuit.pdf&usg=AOvVaw3-7O5mtRxdG2HQmGHcuHWs&opi=89978449>

## **RELEVANT AMA POLICY**

### **AMA Policy on ERISA H-285.915**

1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate federal patient protection legislation, through enactment of similar state patient protection legislation that is uniform across states, and through targeted elimination of the ERISA preemption of self-insured health benefits plans from state regulation, to require that such self-insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b) Clearly disclose to present and prospective enrollees any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians; (c) Be regulated in regard to plan policies and practices regarding utilization management, claims submission and review, and appeals and grievance procedures; (d) Conduct scientifically based and physician-directed quality assurance programs; (e) Be legally accountable for harm to patients resulting from negligent utilization management policies or patient treatment decisions through all available means, including proportionate or comparative liability, depending on state liability rules; (f) Participate proportionately in state high-risk insurance pools that are financed through participation by carriers in that jurisdiction; (g) Be prohibited from indemnifying beneficiaries against actions brought by physicians or other providers to recover charges in excess of the amounts allowed by the plan, in the absence of any provider contractual agreement to accept those amounts as full payment; (h) Inform beneficiaries of any discounted payment arrangements secured by the plan, and base beneficiary coinsurance and deductibles on these discounted amounts when providers have agreed to accept these discounted amounts as full payment; (i) Be subject to breach of contract actions by providers against their administrators; and (j) Adopt coordination of benefits provisions applying to enrollees covered under two or more plans.

Citation: CMS Rep. 6, I-96; Reaffirmed: A-97; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: Sub Res 202, A-98; Renumbered: CMS Rep. 7, I-05; Reaffirmed and Modified: Res. 223, I-10; Reaffirmed in lieu of Res. 235, A-11; BOT Action in response to referred for decision Res. 235, A-11; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed in lieu of: Res 235, A-17; Reaffirmed: Res. 206, I-20

### **ERISA and Managed Care Oversight D-383.984**

Our AMA will develop, propose, and actively support (1) federal legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues; (2) federal legislation that requires all third party payers serving as administrators for ERISA plans to accept assignment of benefits by patients to physicians; and (3) federal and state legislation prohibiting "all products" clauses or linking participation in one product to participation in other products ("tied") administered or offered by third party payers or their affiliates.

Citation: Res 915, I-06; Reaffirmed: Res. 223, I-10; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: BOT Rep. 9, A-22

### **ERISA Preemption and State Prompt Pay Laws D-385.984**

- (1) Our AMA continue to actively work with constituent societies to advocate for strong prompt payment laws, as well as full enforcement and implementation of those laws.
- (2) Our AMA Advocacy Resource Center disseminate information to the Federation regarding the issue of Employee Retirement Income Security Act preemption and state prompt pay laws, including specific guidance for drafting legislation to best avoid preemption.
- (3) Our AMA continue to seek legal avenues for advancing the case against ERISA preemption of state prompt pay laws.
- (4) Our AMA monitor developments with regard to implementation of the U.S. Department of Labor claims processing regulation and provide information to the federation on any significant developments.

Citation: BOT Rep. 16, I-02; Reaffirmed: A-10; Reaffirmed; CMS Rep. 6, A-12; Reaffirmed: A-14; Reaffirmed in lieu of: Res. 235, A-17

### **ERISA and Health Plan Related Legislation D-190.996**

Our AMA will continue to urge state medical associations to undertake surveys of their members regarding payment delays by health plans so that physicians will be aware of plans that are delaying payment and that may be financially weak.

Citation: BOT Rep. 7, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

### **ERISA Plans and the United States Department of Labor D-385.973**

1. Our AMA will seek federal legislation that would modify Employee Retirement Income Security Act law to incorporate a clause that addresses timely payment of medical claims of health care practitioners who provide treatment in good faith to the members of self-funded group employer-sponsored health plans.
2. When the federal law is amended, our AMA will work with the United States Department of Labor to devise and implement a formalized appeal process at the United States Department of Labor.

Citation: Res. 213, A-07; Reaffirmed: A-10; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: A-14; Reaffirmed in lieu of: Res. 235, A-17

**Requiring Third Party Reimbursement Methodology be Published for Physicians H-185.975**

Our AMA:

- (1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules;
- (2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans;
- (3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted.
- (4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies;
- (5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and
- (6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer.

Citation: Sub. Res. 805, I-95; Appended: Res. 117, A-98; Reaffirmed: A-99; Appended: Res. 219, and Reaffirmed: CMS Rep. 6, A-00; Reaffirmed: I-01; Reaffirmed and Appended: Res. 704, A-03; Reaffirmed; I-04; Reaffirmed: A-08; Reaffirmed: A-08; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: A-14

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229  
(I-23)

Introduced by: Organized Medical Staff Section

Subject: Facilitating Appropriate Reimbursement of Diagnostic Radiopharmaceuticals

Referred to: Reference Committee B

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1 Whereas, Through exciting innovations in diagnostic radiopharmaceuticals, doctors are finding  
2 new ways to diagnose and monitor conditions such as Alzheimer's, Parkinson's disease,  
3 advanced cardiac disease, and cancers of the prostate, breast, and brain; and  
4

5 Whereas, Medicare's current reimbursement structure limits patient access to innovative  
6 imaging tools that improve diagnosis of these deadly diseases; and  
7

8 Whereas, By reimbursing diagnostic radiopharmaceuticals as "supplies" through a "packaged"  
9 payment system, the current Medicare payment methodology creates a significant barrier to  
10 patient access to the newer, more precise generation of diagnostic nuclear imaging drugs; and  
11

12 Whereas, The current reimbursement model reimburses at a rate significantly less the cost of  
13 acquiring these important radiopharmaceuticals; and  
14

15 Whereas, Many hospitals and healthcare clinics, for economic reasons, may need to limit or  
16 completely end the utilization of these irreplaceable diagnostic tools due to the loss incurred  
17 with each radiopharmaceutical dose order; and  
18

19 Whereas, To provide the best diagnostic and therapeutic care, hospitals medical staffs are in  
20 urgent need of passage of such corrective legislation to best care for their patients; and  
21

22 Whereas, There are two bicameral bipartisan bills introduced once again this year, namely H.R.  
23 1199 and S. 1544, each entitled "Facilitating Innovative Nuclear Diagnostics Act of 2023" to  
24 address fixes for this issue; and  
25

26 Whereas, These bills would establish separate payment requirements for diagnostic  
27 radiopharmaceuticals under the Medicare prospective payment system for hospital outpatient  
28 department services; and  
29

30 Whereas, These bills' requirements apply specifically to diagnostic radiopharmaceuticals that  
31 have an average daily cost of \$500 or more in 2024 and would be adjusted based on a specified  
32 fee schedule factor in each year thereafter; and  
33

34 Whereas, Passage of these bicameral bipartisan bills would significantly serve to ameliorate the  
35 problem of the prohibitive under-reimbursement of these novel diagnostic tools which can  
36 otherwise direct the diagnosis and therapy of many debilitating and deadly diseases; therefore  
37 be it  
38  
39  
40

1 Resolved, That our American Medical Association advocate with the congress and with Centers  
2 for Medicare and Medicaid Services to change the categorization of diagnostic  
3 radiopharmaceuticals by the Hospital Outpatient Prospective Payment System (OPPS) from  
4 “supplies” to correctly classify them as “drugs,” as would be consistent with the Medicare  
5 Modernization Act (MMA) of 2003, and which will allow diagnostic radiopharmaceuticals, similar  
6 to other drugs, to similarly be paid separately for costs above the packaging threshold of \$140  
7 per-day (Directive to Take Action); and be it further

8  
9 Resolved, That our AMA advocate for congressional efforts to urgently separate payment  
10 requirements for diagnostic radiopharmaceuticals under the Medicare prospective payment  
11 system for hospital outpatient department services to apply to diagnostic radiopharmaceuticals  
12 that are appropriate for the cost of radiopharmaceuticals and that carry a cost above that  
13 applied to them as supplies by Outpatient Prospective Payment System (Directive to Take  
14 Action).

Fiscal Note: Moderate – between \$5,000 and \$10,000

Received: 11/10/23

References:

1. <https://www.congress.gov/bill/118th-congress/house-bill/1199>
2. <https://www.congress.gov/bill/118th-congress/senate-bill/1544?q=%7B%22search%22%3A%5B%22S.+1544%22%5D%7D&s=1&r=1>



## **RELEVANT AMA POLICY**

### **Interference with Practice of Medicine by the Nuclear Regulatory Commission D-455.993**

Our AMA will express its opposition to the imminent proposed changes to the Section 10 CFR Part 35.390(b) by the Nuclear Regulatory Commission (NRC) which would weaken the requirements for Authorized Users of Radiopharmaceuticals (AUs), including shortening the training and experience requirements, the use of alternative pathways for AUs, and expanding the use of non-physicians, with AMA advocacy for such opposition during the open comment period ending July 3, 2019.

Citation: Res. 719, A-19

### **Creation of United Nations "Dr. Saul Hertz Theranostic Nuclear Medicine" International Day D-445.996**

Our AMA will advocate and participate with the United States Mission to the United Nations to create and introduce a United Nations General Assembly Resolution for the creation of a new United Nations International Day of recognition, marking March 31 as: "Dr. Saul Hertz Theranostic Nuclear Medicine Day," commemorating the day the first patient was treated with therapeutic radionuclide therapy on that day in 1941, marking the advent of theranostic medicine.

Citation: Res 624, A-22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230  
(I-23)

Introduced by: Organized Medical Staff Section

Subject: The Corporate Practice of Medicine, Revisited

Referred to: Reference Committee B

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1 Whereas, Primary interests of our American Medical Association include sustaining and  
2 improving public health, as well as the sustainability of medical autonomy in practice; and  
3

4 Whereas, For decades, the American Medical Association has maintained a policy that deems  
5 unprofessional any contractual arrangement that interferes with physician practice and by so  
6 stating, bars unlicensed lay entities from owning or controlling medical practices; and  
7

8 Whereas, In the current evolution of the healthcare system, increasingly corporate entities  
9 including public companies and private equity firms have entered into the arena of healthcare  
10 provision with ownership interests; and  
11

12 Whereas, Those ownership interests have become controlling interests in the vast majority of  
13 cases, despite most states maintaining laws against the corporate practice of medicine to one  
14 degree or another<sup>(1,2)</sup>; and  
15

16 Whereas, There are a number of subterfuges by which lay entities get around restrictions  
17 against the corporate practice of medicine, including but not limited to intermediate  
18 organizations known as medical service organizations (MSOs) as well as “friendly private  
19 corporation (PC) models,” wherein there is dual participation by a licensed physician in both eht  
20 practice and the medical service organization<sup>(1,2)</sup>; and  
21

22 Whereas, Medical service organizations and other public entities include those of hospital care  
23 based organizations, by virtue of medical management oversight, contracting intermediaries,  
24 etc. have undue influence on the provision of healthcare by the physician to the patient,  
25 essentially dictating type, amount and directions of care<sup>(1,2)</sup>; and  
26

27 Whereas, The justification that consolidation of care and control over clinical operations will  
28 improve quality and reduce cost of giving healthcare is not substantiated, even contradicted, by  
29 academic research to date<sup>(1-3)</sup>; and  
30

31 Whereas, In some notable instances, private equity firms that focus on financial bottom line  
32 outcomes increasingly resort to substitutions of physicians with nonphysician practitioners, as  
33 well as creating environments where there is greater turnover even of physicians (sometimes  
34 due to “moral burnout”), which has been shown to reduce the quality of healthcare<sup>1</sup>; and  
35

36 Whereas, Our AMA Advocacy Resource Center posted an issue brief on the corporate practice  
37 of medicine in 2015<sup>4</sup>; and

38 Whereas, Our AMA recently established policy (H-215.981) to “provide guidance, consultation,  
39 and model legislation regarding the corporate practice of medicine...[and]...continue to monitor

1 the evolving corporate practice of medicine” but did not establish a mechanism to gather and  
2 disseminate that information; and  
3

4 Whereas, There is renewed attention paid to the erosion of the firewall represented by the  
5 original prohibition of the corporate practice of medicine in several recent studies and  
6 articles<sup>(1,2)</sup>; therefore be it  
7

8 Resolved, That our American Medical Association revisit the concept of restrictions on the  
9 corporate practice of medicine, including private equities, hedge funds and similar entities,  
10 review existing state laws and study needed revisions and qualifications of such restrictions  
11 and/or allowances, in a new report to our House of Delegates by Annual 2024 that will inform  
12 advocacy to protect the autonomy of physician-directed care, patient protections, medical staff  
13 employment and contract conflicts, and access of the public to quality healthcare, while  
14 containing healthcare costs (Directive to Take Action).

Fiscal Note: Moderate – between \$5,000 and \$10,000

Received: 11/10/23

## References

1. [Perspective](#): “A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine”; Jane M. Zhu, M.D., M.P.P., M.S.H.P., Hayden Rooke-Ley, J.D., and Erin Fuse Brown, J.D., M.P.H.; [September 14, 2023](#); N Engl J Med 2023; 389:965-968, DOI: 10.1056/NEJMp2306904

2. Audio interview with Erin Fuse Brown, professor of law, on the role of corporate practice of medicine laws in a changing health care environment;  
<https://www.nejm.org/action/showMediaPlayer?doi=10.1056%2FNEJMdo007232&aid=10.1056%2FNEJMp2306904&area=>

3. Utilization, Steering, and Spending in Vertical Relationships Between Physicians and Health Systems; Anna D. Sinaiko, PhD1; Vilsa E. Curto, PhD1; Katherine Ianni, BA2; et al Mark Soto, MA1; Meredith B. Rosenthal, PhD1 ;September 1, 2023; JAMA Health Forum. 2023;4(9):e232875. doi:10.1001/jamahealthforum.2023.2875

4. AMA Advocacy Resource Center

Issue brief: Corporate practice of medicine;  
[https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjV56\\_U4dWBAXV-LFkFHUNPCggQFnoECA8QAQ&url=https%3A%2F%2Fwww.ama-assn.org%2Fmedia%2F7661%2Fdownload&usg=AOvVaw3I0sn8SPujJDC8-wyv9tsD&opi=89978449](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjV56_U4dWBAXV-LFkFHUNPCggQFnoECA8QAQ&url=https%3A%2F%2Fwww.ama-assn.org%2Fmedia%2F7661%2Fdownload&usg=AOvVaw3I0sn8SPujJDC8-wyv9tsD&opi=89978449)

## RELEVANT AMA POLICY

### **Corporate Practice of Medicine H-215.981**

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.
3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

Citation: Res. 247, A-91; Reaffirmed; Sunset Report, I-09; Reaffirmed: CMS Rep. 7, A-11; Modified: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 07, A-17; Modified Res. 713, A-18; Reaffirmed: CMS Rep. 11, A-19; Reaffirmed: CME Rep. 01, I-22

### **Corporate Practice of Medicine H-160.887**

Our AMA acknowledges that the corporate practice of medicine: (1) has the potential to erode the patient-physician relationship; and (2) may create a conflict of interest between profit and best practices in residency and fellowship training.

Citation: CMS Rep. 2, I-22

### **Corporate Investors H-160.891**

1. Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
  - a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
  - b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
  - c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
  - d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
  - e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
  - f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
  - g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.

- h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
- i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
- j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
- k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.

3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.

4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

Citation: CMS Rep. 11, A-19; Appended: CMS Rep. 2, I-22; Reaffirmed: BOT Rep. 14, A-23

### **Physician-Owned Hospitals D-215.983**

- 1. Our American Medical Association will advocate for policies that remove restrictions upon physicians from owning, constructing, and/or expanding any hospital facility type.
- 2. Our AMA will study and research the impact of the repeal of the ban on physician-owned hospitals on the access to, cost, and quality of, patient care, and the impact on competition in highly concentrated hospital markets.
- 3. Our AMA will collaborate with other stakeholders to develop and promote policies that support physician ownership of hospitals.

Citation: Res. 219, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231  
(I-23)

Introduced by: Organized Medical Staff Section

Subject: Deceptive Hospital Badging 2.0

Referred to: Reference Committee B

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1 Whereas, The public is wholly unaware of the false labeling for care personnel in the hospital,  
2 with the increasing introduction of lesser trained people appearing to be equivalent caregivers;  
3 and  
4

5 Whereas, The most recent addition to this group of non-physicians are the CRNAs, increasing  
6 replacing anesthesiologists; and  
7

8 Whereas, This has crept into our cardiac suite of ORs, with increasing fallout as surgeons are  
9 being tasked with assuming responsibility and therefore enhanced liability for these non-MD  
10 personnel; and  
11

12 Whereas, Anesthesia was also overseeing perfusion, which will now fall to surgeons who may  
13 not be up to speed to perform these additional tasks; and  
14

15 Whereas, This is unquestionably a quality of care issue as well as safety related, along with a  
16 PR, cost, and billing problem; and  
17

18 Whereas, We were able to correct the previous deception at our hospital with a push by the  
19 organized medical staff taking action, along with the support of the AMA; therefore be it  
20

21 Resolved, That our American Medical Association promote and prioritize public awareness of  
22 the difference and importance of having proper level of training and clear identification and  
23 labeling of caregivers as that relates to quality and safety of health care (Directive to Take  
24 Action); and be it further  
25

26 Resolved, That our AMA work with state and county medical societies to highlight to physicians  
27 the growing practice of creating false equivalencies between physicians and non-physicians in  
28 the healthcare team and encourage action in local institutions to assure the quality and safety of  
29 patient care (Directive to Take Action).

Fiscal Note: Moderate – Between \$5,000 and \$10,000

Received 11/10/23

## **RELEVANT AMA POLICY**

### **Clarification of the Title "Doctor" in the Hospital Environment D-405.991**

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.
2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

Citation: Res. 846, I-08; Modified: BOT Rep. 9, I-09; Reaffirmed: CCB/CLRPD Rep. 01, A-23

### **Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation D-35.992**

Our AMA will: (1) work jointly with state attorneys general to identify and prosecute those individuals who misrepresent themselves as physicians to their patients and mislead program applicants as to their future scope of practice; (2) pursue all other appropriate legislative, regulatory and legal actions through the Scope of Practice Partnership, as well as actions within hospital staff organizations, to counter misrepresentation by nurse doctoral programs and their students and graduates, particularly in clinical settings; and (3) work with all appropriate entities to ensure that all persons engaged in patient contact be clearly identified either verbally, or by name badge or similar identifier, with regard to their professional licensure in order that patients are aware of the professional educational background of that person.

Citation: Res. 211, A-06; Reaffirmed: BOT Rep. 6, A-16

### **Professional Nurse Staffing in Hospitals H-360.986**

The AMA: (1) encourages medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients;

(2) encourages medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care;

(3) encourages medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care;

(4) encourages medical and nursing staffs to develop, promote, and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs at each facility; and

(5) encourages medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured.

Citation: BOT Rep. 11, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232  
(I-23)

Introduced by: Private Practice Physicians Section

Subject: Access to Covered Benefits with an Out of Network Ordering Physician

Referred to: Reference Committee B

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1 Whereas, Physicians have not had inflationary increases like other service providers have for  
2 decades in the Medicare program; and  
3

4 Whereas, Physicians' ability to continue to serve patients independent of hospital systems,  
5 private equity, vertically and/or horizontally consolidated systems has narrowed under current  
6 reimbursement settings<sup>6</sup>; and  
7

8 Whereas, Between 2019 and 2020, 48,400 physicians left independent practice according to a  
9 2021 Physicians Advocacy Institute study<sup>1</sup>; and  
10

11 Whereas, As a result there is a growing number of private practice physicians using the Direct  
12 Primary Care (DPC) model not accepting insurance or otherwise treating patients in models that  
13 are not in-network with HMOs, PCOs, Medicare Advantage or other health plans<sup>(2,3)</sup>; and  
14

15 Whereas, There are 2,060 direct primary care practices spanning 48 states<sup>4</sup>; and  
16

17 Whereas, Patients with catastrophic plans with high deductibles are well-served by having  
18 access to direct primary care physicians<sup>5</sup>;" and  
19

20 Whereas, Physicians who care for patients under the direct primary care model or other out of  
21 network models are not compensated by insurers for physician services rendered to patients  
22 with these plans; and  
23

24 Whereas, Many of the patients served in direct primary care or out of network models have  
25 HMOs, PCOs, Medicare Advantage or other health plans for their primary insurance while using  
26 a direct pay physician for their medical care; and  
27

28 Whereas, These health plans often will not cover laboratory studies, radiology studies, referral,  
29 or even prescription medications when ordered by one of these out-of-network physicians; and  
30

31 Whereas, Non-coverage of valid orders for health plan benefits for the insured leads to delays in  
32 care, increased cost to patients and redundancy and inefficiency in the healthcare system;  
33 therefore be it  
34

35 Resolved, That our American Medical Association develop model legislation to protect patients  
36 in direct primary care plans and non-network plans thus furthering the ability of direct primary  
37 care physicians and other out of network physicians to provide covered services, including  
38 imaging, laboratory testing, referrals, medications, and other medically-necessary services for  
39 patients under their commercial insurance, even if it is an HMO or POS plan (Directive to Take  
40 Action); and be it further

1 Resolved, That our AMA develop model legislation to protect patients in direct primary care  
2 plans and non-network plans thus furthering the ability of direct primary care physicians and  
3 other out network physicians to order or provide such covered services to their patients under  
4 their Medicare Advantage plans (Directive to Take Action); and be it further

5  
6 Resolved, That our AMA develop resources, tool kits, education, and internal experts to support  
7 direct primary care and other out of network models (Directive to Take Action).

Fiscal Note: Moderate – between \$5,000 and \$10,000

Received: 11/10/23

#### References:

- 1) Physicians Advocacy Group, Covid 19's Impact on Physician Practices and Physician Employment 2019-2020- Prepared by Avalere Health June 2021 tma.tips/PAIStudy2021.
- 2) Cobra KL. Direct primary care may be the link to the “fourth aim” of healthcare. *Medical Economics*. Published July 11, 2018. Accessed January 12, 2021. <https://www.medicaleconomics.com/view/direct-primary-care-may-be-link-fourth-aim-healthcare>
- 3) AM J Lifestyle Med, 2021 Sept-Oct 15(5):557-562.
- 4) Mapper.dpcfrontier.com
- 5) Direct Primary Care: Update and Roadmap for Patient Centered Reforms. The Heritage Foundation Backgrounder No. 3635. June 28, 2021.
- 6) State of Maine Department of Professional and Financial Regulation, Bureau of Insurance, Bulletin 434 Referrals by Out of Network Direct Primary Care Providers, June 7, 2019
- 7) Health Services Research 2020 Aug;55(4) 491-495.

## **RELEVANT AMA POLICY**

### **Direct Primary Care H-385.912**

1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.

Citation: Res. 103; A-16; Appended: Res. 246, A-18; Reaffirmed: A-18; Reaffirmed: I-18;  
Appended: Res. 102, A-19

### **Subacute Care Standards for Physicians H-160.945**

AMA guidelines for physicians' responsibilities in subacute care include:

- (1) Physicians are responsible to their patients for delivery of care in all subacute care settings, 24 hours a day, 7 days a week.
- (2) Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care.
- (3) Physicians are responsible for coordinating care for their patients with other physicians including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings.
- (4) Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care.
- (5) Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations.
- (6) Physicians are responsible for: (a) Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care. (b) Identifying and appropriately utilizing subacute care facilities in their communities. (c) Oversight of physician credentialing in subacute settings (d) Promoting medical staff organization and by-laws that may be needed to support peer evaluations. (e) Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life.
- (7) Subacute units and/or programs need physician medical directors to assure quality of

medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs.

(8) Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care.

(9) Attending physicians should: (a) make an on-site visit to review the interdisciplinary care plan within seventy two hours of admission. (b) Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly. (c) Document active involvement of physicians in interdisciplinary care and all major components of the patient care plan including completing a progress note for each patient visit.

(10) Physicians should implement these guidelines through organized medical staff by-laws in subacute settings to assure quality patient care.

Citation: BOT Rep. 21, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15

#### **Out-of-Network Care H-285.904**

1. Our AMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified.

Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Citation: Res. 108, A-17; Reaffirmed: A-19; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, A-18; Reaffirmed: A-19; Reaffirmed: Res. 210, A-19; Appended Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22

#### **Out-of-Network Care D-285.962**

Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care.

Citation: Res. 108, A-17

#### **Physician Penalties for Out-of-Network Services H-180.952**

Our AMA vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services.

Citation: Res. 702, A-07; Reaffirmed: CMS Rep. 01, A-17

#### **Out of Network Restrictions of Physicians H-285.907**

Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.

Citation: Res. 126, A-15

#### **Out of Network Coverage Denials for Physician Prescriptions and Ordered Services D-285.963**

Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service.

Citation: Res. 119, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233  
(I-23)

Introduced by: Private Practice Physicians Section, Organized Medical Staff Section

Subject: Corporate Practice of Medicine Prohibition

Referred to: Reference Committee B

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Whereas, A majority of physicians are employed with no ownership in their practice (74 percent of 2022<sup>1</sup>); and

Whereas, This lack of physician ownership, especially in the setting of private equity ownership, leads to a prioritization of profits over quality patient care due to understaffing, replacement of physicians with non-physician practitioners and an inflation of costs to the patients as seen with increases in out-of-network charges and “surprise billing”<sup>(2-4)</sup>; and

Whereas, The corporate practice of medicine (CPOM) doctrine is a legal prohibition that exists in many states to keep the business interest out of the physician-patient relationship, specifically prohibits the ownership and operation of medical groups or practices by laypersons; and

Whereas, The CPOM prohibition has as its main purpose the protection of patients and the avoidance of the commercialization of the practice of medicine; and

Whereas, Private equity ownership and corporate practice of medicine constitutes a financial conflict of interest that harms the physician-patient relationship and the quality of healthcare; and

Whereas, Our American Medical Association policy Corporate Practice of Medicine (H-215.981) states that “1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine;” and

Whereas, The COPM doctrine prohibiting or restricting layperson ownership is law in 33 states, however it is poorly enforced and even in states with strong COPM laws the law is skirted<sup>(5,6)</sup>; and

Whereas, Our AMA policy Corporate Practice of Medicine acknowledges the potential erosion of the physician-patient relationship and conflict of interest in training environments corporate practice of medicine imposes; therefore be it

Resolved, That our American Medical Association amend policy H-215.981, Corporate Practice of Medicine, by deletion and substitution to read as follows:

1. Our AMA ~~vigorously opposes any effort to pass~~ will seek federal legislation to preempting state laws prohibiting the corporate practice of medicine by limiting ownership and corporate control of physician medical practices to physicians or physician-owned groups only and ensure private equity/non-medical groups do not have a controlling interest.

2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.
  3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues
- (Directive to Take Action).

Fiscal Note: Moderate – between \$5,000 and \$10,000

Received: 11/10/23

#### References:

1. Physician Advocacy Institute. A Physician Employment Trends Study 2019-2021. [https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB\\_yZflmFdXlvGg%3d%3d](https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZflmFdXlvGg%3d%3d)
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6. Zhu, J, et al. A Doctrine in Name Only - Strengthening Prohibitions against the Corporate Practice of Medicine. Massachusetts Medical Society, NEJM Sep 2023, 389:11, 965-968. <https://doi.org/10.1056/NEJMp2306904>

## **RELEVANT AMA POLICY**

### **Corporate Practice of Medicine H-160.887**

Our AMA acknowledges that the corporate practice of medicine: (1) has the potential to erode the patient-physician relationship; and (2) may create a conflict of interest between profit and best practices in residency and fellowship training.

Citation: CMS Rep. 2, I-22

### **Corporate Practice of Medicine H-215.981**

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.
3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

Citation: Res. 247, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11;  
Modified: CMS Rep. 6, I-13



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308  
(I-23)

Introduced by: Maryland

Subject: Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA  
Level 1 Examinations

Referred to: Reference Committee C

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1 Whereas, in September 2021, the United States Medical Licensing Examination (USMLE)  
2 made an official announcement regarding the implementation of a revised assessment  
3 format for STEP1, wherein the conventional numeric scoring system and binary pass/fail  
4 outcomes would be replaced solely with a pass/fail designation for examinations  
5 commencing in January 2022<sup>1</sup>; and  
6

7 Whereas, alongside this transition, the passing threshold for STEP1 was heightened, and the  
8 permissible number of attempts was reduced from six to four,<sup>1</sup> with the aim of alleviating the  
9 psychological burden commonly associated with the examination process, while concurrently  
10 fostering a more comprehensive evaluation of applicants; and  
11

12 Whereas, the pass rate for all examinees in 2022 declined to 82%, compared to the previous  
13 rate of 88% in 2021 prior to the introduction of the new scoring system;<sup>2</sup> and  
14

15 Whereas, studies have indicated significant performance disparities between men and  
16 women taking STEP1, as well as variations based on the age at the time of examination;<sup>3,4</sup>  
17 and  
18

19 Whereas, the process of preparing for and undertaking the USMLE STEP1 exam has been  
20 associated with excessive stress and social isolation<sup>5</sup>; and  
21

22 Whereas, research has revealed that medical students encounter higher levels of burnout,  
23 depressive symptoms, suicidal ideation, and substance use compared to the general  
24 population;<sup>6,7</sup> and  
25

26 Whereas, the transition to a binary scoring system has led to heightened pressure to pass  
27 the exam on the first attempt; and  
28

29 Whereas, the implementation of the pass/fail scoring system has also led to an increased  
30 emphasis on extracurricular activities and the STEP2 exam, a more clinically relevant exam,  
31 as the primary means of distinguishing applicants and maintaining competitiveness;<sup>8</sup> and  
32

33 Whereas, in contrast to the STEP2 exam, STEP1 is considered less clinically relevant and an  
34 inadequate indicator of future professional competence as a physician;<sup>9</sup> and

Whereas, given that STEP1 has moved to pass/fail and is now a mere threshold to be crossed, lacks clinical significance compared to STEP2, and is an inadequate indicator of future professional competence as a physician, it is reasonable to move away from reporting failed attempts or total number of attempts to residency and fellowship programs, as well as licensure authorities; and

Whereas, transitioning away from reporting failed attempts on the STEP1 and Level 1 examinations would be another potential avenue to better support medical student mental health and wellness and would align with the goal of creating a more comprehensive and balanced evaluation of medical students; and

Whereas, our AMA has ample policy regarding supporting the mental health and wellness of trainees in both the undergraduate and graduate medical education levels (H-345.970); and

Whereas, our AMA has expressed its support for the holistic review of medical school applicants and has encouraged residency directors not to utilize ranked passing scores as a screening criterion (H-275.953); therefore be it

RESOLVED, that our American Medical Association advocate that NBME and NBOME cease reporting the total number of attempts of the STEP1 and COMLEX-USA Level 1 examinations to residency and fellowship programs and licensure. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 11/1/23

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1. USMLE. USMLE Step 1 Transition to Pass/Fail Only Score Reporting. 2023. <https://www.usmle.org/usmle-step-1-transition-passfail-only-score-reporting>
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4. Gauer JL, Jackson JB. Relationships of demographic variables to USMLE physician licensing exam scores: a statistical analysis on five years of medical student data. *Adv Med Educ Pract*. 2018;9:39-44. doi:10.2147/amep.S152684
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9. Cuddy MM, Young A, Gelman A, et al. Exploring the Relationships Between USMLE Performance and Disciplinary Action in Practice: A Validity Study of Score Inferences From a Licensure Examination. *Acad Med*. Dec 2017;92(12):1780-1785. doi:10.1097/acm.0000000000001747

#### RELEVANT AMA POLICY

##### **The Grading Policy for Medical Licensure Examinations H-275.953**

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive

“pass/fail” scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.

3. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.

4. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores.

#### **Improving Mental Health Services for Undergraduate and Graduate Students H-345.970**

Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309  
(I-23)

Introduced by: Private Practice Physicians Section

Subject: The Role of Maintenance of Certification

Referred to: Reference Committee C

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1 Whereas, The principle of lifelong learning is fundamental to maintaining and enhancing the  
2 quality of patient care delivered by physicians; and  
3

4 Whereas, Continuing medical education (CME) already plays a pivotal role in facilitating lifelong  
5 learning by offering opportunities for physicians to stay current with advances in medical  
6 knowledge and technology; and  
7

8 Whereas, Specialty boards contend that the process of re-certification and maintenance of  
9 certification (MOC) contributes to the enhancement of patient care quality by counteracting a  
10 natural decline in medical knowledge and skills over time during active practice, although  
11 existing evidence is at odds with this assertion and does not suggest that re-certification and  
12 MOC significantly enhance the quality of care provided by physicians<sup>(1,2)</sup>; and  
13

14 Whereas, The current landscape of board certification lacks sufficient competition which has  
15 resulted in elevated costs for physicians seeking certification in their respective specialties,  
16 competition policy experts noting the harms of consolidation in the market for certification,  
17 spirited public debate amongst physicians about the value of MOC to both patients and  
18 physicians, and the Department of Justice advocating for efforts to increase competition in the  
19 market for physician board certification<sup>(3-6)</sup>; and  
20

21 Whereas, The obligation of high-stakes testing as part of MOC is not a comprehensive or  
22 optimal way to assess clinical knowledge or competence for physicians who have maintained  
23 active clinical practice; and  
24

25 Whereas, Our American Medical Association has a responsibility to investigate issues that  
26 impact physicians and their patients; therefore be it  
27

28 Resolved, That our American Medical Association adopt policy that states that MOC  
29 requirements should not be duplicative of CME requirements and not be used to determine or  
30 dictate hospital privileges, insurance network credentialing, or hiring practices (New HOD  
31 Policy); and be it further  
32

33 Resolved, That our American Medical Association recognizes the importance of fostering  
34 competition in the market for board certification, allowing physicians to have the autonomy to  
35 choose the most suitable pathway for their individual learning and professional development  
36 needs (New HOD Policy); and be it further  
37

38 Resolved, That our American Medical Association undertake a comprehensive review of the  
39 available evidence concerning the impact of maintenance of certification on the quality and  
40 safety of patient care and report the findings of this investigation to its members and

- 1 stakeholders, including policymakers and legislators, to inform future healthcare policy with a
- 2 report back to the House of Delegate by Interim 2024 (Directive to Take Action).

Fiscal Note: \$50,000 for external consulting and data collection

Received: 11/10/23

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6. Comments on Maintenance of Certification Requirements for Physicians. Accessed August 26, 2023. <https://www.justice.gov/atr/page/file/1212231/download>

## RELEVANT AMA POLICY

### Continuing Board Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.

15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model

medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.

37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.

38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.

39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.

Citation: CME Rep. 2, I-15; Appended: Res. 911, I-15; Appended: Res. 309, A-16; Appended: CME Rep. 02, A-16; Appended: Res. 307, I-16; Appended: Res. 310, I-16; Modified: CME Rep. 02, A-17; Reaffirmed: Res. 316, A-17; Reaffirmed in lieu of: Res. 322, A-17; Appended: CME Rep. 02, A-18; Appended: Res. 320, A-18; Appended: Res. 957, I-18; Reaffirmation: A-19; Modified: CME Rep. 02, A-19; Appended: CME Rep. 1, I-20; Appended: Res. 310, A-21; Modified: CME Rep. 2, A-22; Appended: Res. 310, I-22

### **MOC Provisions of Interstate Medical Licensure Compact D-275.955**

Our American Medical Association will, in collaboration with the Federation of State Medical Boards and interested state medical boards, request a clarifying statement from the Interstate Medical Licensure Compact Commission that the intent of the language in the model legislation requiring that a physician "holds" specialty certification refers only to initial specialty certification recognized by the American Board of Medical Specialties or the American Osteopathic Association's (AOA's) Bureau of Osteopathic Specialists and that there is no requirement for participation in ABMS's Maintenance of Certification or AOA's Osteopathic Continuous Certification (OCC) program in order to receive initial or continued licensure under the Interstate Medical Licensure Compact.

Citation: Res. 235, A-15



**An Update on Maintenance of Licensure D-275.957**

Our American Medical Association will:

1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.
3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.
4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.
5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.
6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.
7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.
8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.

Citation: CME Rep. 3, A-15; Modified: CME Rep. 2, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609  
(I-23)

Introduced by: Organized Medical Staff Section

Subject: Advocacy Education Towards a Sustainable Medical Care System

Referred to: Reference Committee F

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1 Whereas, extensive AMA policy and action address education of medical students and  
2 physicians on advocacy techniques and their involvement in AMA advocacy efforts; and  
3

4 Whereas, our AMA believes that “better-informed and more active citizens will result in better  
5 legislators, better government, and better health care” (AMA policy G-640.020); and  
6

7 Whereas, AMA currently facilitates some patient education and engagement in advocacy efforts  
8 via its Patient Action Network (PAN); and  
9

10 Whereas, greater involvement of the public in AMA advocacy efforts potentially could make  
11 AMA more effective in its advocacy on behalf of patients and the profession; and  
12

13 Whereas, any attempt to engage the public must consider the potential difficulties that can arise  
14 from blending the perspectives of physicians and patients; therefore be it  
15

16 RESOLVED, that our American Medical Association explore innovative opportunities for  
17 engaging the public in advocacy on behalf of an improved healthcare environment. (Directive to  
18 Take Action)  
19

Fiscal Note: Moderate – between \$5,000 - \$10,000

Received: 11/10/23

## **RELEVANT AMA POLICY**

### **Medical Student, Resident and Fellow Legislative Awareness H-295.953**

1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.
2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.

### **Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy G-615.103**

Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy; and (4) study mechanisms to mitigate costs incurred by medical students, residents and fellows who participate at national, in person AMA conferences.

### **Political Action Committees and Contributions G-640.020**

Our AMA: (1) believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; (8) calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries; and (9) calls upon all candidates for public office to refuse contributions from any organization that opposes evidence-based public health measures to reduce firearm violence.

### **Physician Health Policy Opportunity G-640.035**

Our AMA encourages and supports efforts to educate interested medical students, residents, fellows, and practicing physicians about health policy and assist them in starting or transitioning to careers that involve health policy.

Our AMA: (a) recognizes, encourages, and supports the primary health policy training found in the physician specialties of Public Health / General Preventive Medicine, Occupational and Environmental Medicine, and Aerospace Medicine; (b) will significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy training opportunities and help them to apply for and participate in them; (c) will engage with alumni of health policy training programs and joint degree programs and provide opportunities for them to share their health policy experiences with medical students, residents, fellows, and practicing physicians; (d) will include health policy content in its educational resources for members; (e) will work with the Office of the U.S. Surgeon General to disseminate information to medical students, residents, fellows, and practicing physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service; and (f) will consider options for funding a 1-year educational training program for practicing physicians who wish to transition from clinical practice to employment within the health policy sector.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 610  
(I-23)

Introduced by: Resident and Fellow Section; Minority Affairs Section; Medical Student Section

Subject: End Attacks on Health and Human Rights in Palestine and Israel

Referred to: Reference Committee F

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*Preamble: The following resolution addresses ongoing events in Israel and Palestine, events which warrant our imminent collective attention, due to the scale of danger to our international medical colleagues and civilians alike. There has been an extraordinary and harmful global increase in Islamophobic, anti-Middle Eastern, and anti-Semitic statements and behaviors in the past month. As we bring forward this resolution to the house of medicine, which we feel is urgently needed, we hope simultaneously to safeguard our members from both intentional and unintentional harm resulting from the conversation we are about to have. We request that all members who speak make their comments with compassion to all sides and all individuals who may be impacted by these events. Throughout this conversation, please remember there are people in the room who have had friends and family killed both on the Israeli and Palestinian sides of this violence. Though the conflict is far from here, its impacts land very close to home for some among us. We wish to frame this resolution in shared recognition of the harms of all forms of hatred and discrimination, and request that the conversations around it center the humanity of the individuals involved.*

1 Whereas, An attack on October 7th resulted in the death of over 1,400 Israelis including around  
2 1,000 civilians, and the displacement of over 200,000 individuals<sup>1</sup>; and  
3

4 Whereas, The resultant escalating crisis in the Gaza Strip, home to over 2.3 million individuals  
5 with half being children, has led to the loss of civilian life surpassing that of any conflict in this  
6 region in the past 17 years and the displacement of 1.4 million civilians to already severely  
7 overcrowded refugee camps<sup>6</sup>; and  
8

9 Whereas, Attacks have resulted in the death of over 10,000 civilians across Gaza, the West  
10 Bank, and Jerusalem, including over 4,100 children, with a further 25,000 wounded and another  
11 2,300 people believed to be buried under rubble<sup>3</sup>; and  
12

13 Whereas, Conflict has spilled over into neighboring nations, with individuals of over 35  
14 nationalities held hostage or killed as a result <sup>4-6</sup>; and  
15

16 Whereas, *The Geneva Conventions* protect journalists, refugees, children, pregnant women and  
17 mothers with infants, civilians, patients, physicians, and other medical personnel during times of  
18 conflict<sup>7</sup>; and  
19

20 Whereas, United Nations (UN) officials proclaim there is “no safe place in Gaza,” as shelters,  
21 refugee camps, hospitals, ambulances, homes, bakeries, places of worship, toy stores, and UN-  
22 funded schools, clinics and shelters have faced airstrikes, shootings, and have been flooded  
23 with poisonous white phosphorous gasses<sup>8-10</sup>; and  
24

25 Whereas, Attacks on healthcare facilities have resulted in the deaths of 136 healthcare

1 personnel<sup>11</sup>; and

2  
3 Whereas, Physicians and other medical personnel have been forced to perform surgeries in  
4 corridors and waiting rooms, conserve supplies due to a lack of basic medical supplies,  
5 anesthetics, or painkillers, and utilize vinegar in place of antibiotics on open wounds<sup>12-15</sup>; and

6  
7 Whereas, Restrictions on the passage of fuel supplies and clean water have led to shutdowns of  
8 medical equipment across hospitals, leaving critically ill patients at especially high risk and  
9 increasing infectious disease outbreaks<sup>9, 16</sup>; and

10  
11 Whereas, The destruction of homes and vital infrastructure, targeting of hospitals and refugee  
12 camps, and depletion of medical resources in the setting of a complete blockade have led to a  
13 critical humanitarian crisis and near complete collapse of the Gazan healthcare system<sup>11</sup>; and

14  
15 Whereas, The head of the United Nations Relief and Works Agency for Palestinian Refugees in  
16 the Near East (UNRWA) informed a UN emergency meeting on Monday October 30, 2023 that  
17 “an immediate humanitarian cease-fire has become a matter of life and death for millions,”<sup>16</sup>;  
18 and

19  
20 Whereas, A ceasefire is defined as a long term suspension of fighting in the entire geographic  
21 area that is agreed upon by all involved parties, and would allow for the continuous flow of  
22 humanitarian aid<sup>17,18</sup>; and

23  
24 Whereas, Numerous leading health care advocacy and humanitarian organizations including  
25 Doctors Without Borders, Amnesty International, Human Rights Watch, the World Health  
26 Organization, and the UN High Commissioner on Human Rights have called for an immediate  
27 ceasefire, safe transit of aid and Gaza's civilian population, and protection of civilian  
28 infrastructure<sup>1,2,19-25</sup>; and

29  
30 Whereas, Many organizations are diligently recruiting volunteers to aid the civilian population in  
31 Gaza, however are unable to enter due to the increasingly unsafe conditions<sup>26-31</sup>; and

32  
33 Whereas, Healthcare professionals and organizations are responsible for upholding medical  
34 neutrality and condemning violence against healthcare infrastructure, hospitals, first responders,  
35 patients, children, refugees, and the blockade of essential health supplies, water, and fuel  
36 including in times of war and siege<sup>1,8,19,32-34</sup>; and

37  
38 Whereas, Our AMA President issued a statement condemning the October 7th attack on Israel,  
39 and the AMA has previously released statements vocalizing solidarity with Ukraine, passed  
40 policy calling for continuous support of organizations providing humanitarian missions to  
41 Ukrainian refugees, and contributed \$100,000 in humanitarian aid through the AMA Foundation  
42 to Ukraine<sup>35,36</sup>; and

43  
44 Whereas, On November 9, 2023, our AMA Board of Trustees released a statement on the  
45 humanitarian crisis in Israel and Palestine, but did not address the pivotal and life-saving issue  
46 of ceasefire<sup>37</sup>; therefore be it

47  
48 **RESOLVED**, That our AMA supports a ceasefire in Israel and Palestine in order to protect  
49 civilian lives and healthcare personnel.

Fiscal Note: Minimal – less than \$1,000

Received: 11/10/23

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## RELEVANT AMA POLICY

### War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993

Our AMA will (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime, episodes of civil strife, or sanctions and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs, and (3) advocate for the protection of physicians' rights to provide ethical care without fear of persecution. Citation: [BOT Action in response to referred for decision Res. 620, A-09 Modified: BOT Rep. 09, A-19 Modified: Res. 002, I-22]

### Medical Neutrality H-520.998

Our AMA supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. Citation: [Sub. Res. 72, I-81 Reaffirmed: CLRPD Rep. F, I-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CEJA Rep. 8, A-11 Reaffirmed in lieu of Res. 601, I-13 Reaffirmed: CEJA Rep. 05, A-23]

### Humanitarian and Medical Aid Support to Ukraine D-65.984

Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. Citation: [Res. 017, A-22]

### Protecting Physicians and Other Healthcare Workers in Society H-515.950

Our AMA: (1) acknowledges and will act to reduce the incidence of antagonistic actions against physicians as well as other health care workers including first responders and public health officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those which appear motivated simply by their identification as health care workers; (2) will educate the general public on the prevalence of violence and personal harassment against physicians as well as other health care workers including first responders, and public health officials, outside as well as within the workplace; and (3) will work with all interested stakeholders to improve safety of health care workers including first responders and public health officials and prevent violence to health care professionals. Citation: Res. [413, I-20]

**A Declaration of Professional Responsibility H-140.900**

Our AMA adopts the Declaration of Professional Responsibility

**DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE's SOCIAL CONTRACT WITH HUMANITY****Preamble**

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all. As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

**Declaration**

We, the members of the world community of physicians, solemnly commit ourselves to: (1) Respect human life and the dignity of every individual.

(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.

(3) Treat the sick and injured with competence and compassion and without prejudice.

(4) Apply our knowledge and skills when needed, though doing so may put us at risk.

(5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

(6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

(7) Educate the public and polity about present and future threats to the health of humanity.

(8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

(9) Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Citation: [CEJA Rep. 5, I-01 Reaffirmation A-07 Reaffirmed: CEJA Rep. 04, A-17 Reaffirmed: Res. 215, A-23]

**Condemning the Use of Children as Instruments of War H-520.987**

Our AMA: (1) condemns the use of children as instruments of war; and (2) encourages evaluation, treatment, and follow-up for children who have been used as instruments of war. Citation: [Res. 411, I-01 Reaffirmed: CEJA Rep. 8, A-11 Reaffirmed: CEJA Rep. 1, A-21]



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 822  
(I-23)

Introduced by: Resident and Fellow Section

Subject: Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing  
and Condemning Pharmaceutical Price Manipulation

Referred to: Reference Committee J

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1 Whereas, The practice of off-label prescribing, the use of pharmaceutical drugs for an  
2 unapproved indication or in an unapproved age group, dosage, or route of administration, is a  
3 legal and often necessary aspect of medical practice; and  
4

5 Whereas, The vast discrepancy in prescription drug pricing places an unreasonable financial  
6 burden on underinsured patients, for example, \$25 per month co-pay with some insurers  
7 compared to approximately \$1,200 per month without coverage for some GLP-1 medications;  
8 and  
9

10 Whereas, Pharmaceutical companies are threatening physicians who prescribe certain  
11 medications off-label for medically necessary indications, potentially jeopardizing medical  
12 licensure; and  
13

14 Whereas, Insurance companies have also warned physicians against medically necessary off-  
15 label prescribing, further restricting clinical decision-making; and  
16

17 Whereas, Such threats interfere with physicians' ability to make appropriate medical judgments  
18 for their patients; and  
19

20 Whereas, Timely action is needed to protect physicians' ability to prescribe off-label based on  
21 medical necessity without repercussions, ensuring access for vulnerable patient populations,  
22 and protecting these vulnerable patient populations from using potentially hazardous fake  
23 compounded versions; and  
24

25 Whereas, Differential pricing and restricted off-label use of medications can exacerbate  
26 healthcare disparities by limiting treatment access for underserved populations; therefore be it  
27

28 RESOLVED, That our AMA advocates for transparency, accountability, and fair pricing practices  
29 in pharmaceutical pricing, opposing differential pricing of medications manufactured by the  
30 same company with the same active ingredient, without clear clinical necessity; and be it further  
31

32 RESOLVED, That our AMA condemns interference with a physician's ability to prescribe one  
33 medication over another with the same active ingredient, without risk of harassment,

- 1 prosecution, or loss of their medical license, and calls on regulatory authorities to investigate
- 2 and take appropriate action against such practices.

Fiscal Note: Minimal – less than \$1,000

Received: 11/10/23

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**REFERENCES:**

1. "Prescribing "Off-Label": What Should a Physician Disclose?" <https://journalofethics.ama-assn.org/article/prescribing-label-what-should-physician-disclose/2016-06> AMA J Ethics. 2016;18(6):587-593. doi: 10.1001/journalofethics.2016.18.6.ecas3-1606.
2. "Understanding Unapproved Use of Approved Drugs "Off Label"<https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label>
3. "Insurers Poised to Crack Down on Off-Label Ozempic Prescriptions" <https://www.webmd.com/obesity/news/20230612/insurers-poised-crack-down-off-label-ozempic-prescriptions>
4. Insurers clamping down on doctors who prescribe Ozempic for weight loss.". [https://www.washingtonpost.com/business/2023/06/11/weight-loss-ozempic-wegovy-insurance/?utm\\_campaign=KHN%3A%20First%20Edition&utm\\_medium=email&hsmi=262066865&hsenc=p2ANqtz-9rlvynBptFsvvj0doDkQYFbvNOgwtFzvPvqY3Lam5feDA5V4gdYZuELna20MTZAFOD\\_wqPN6Ijvzvmi](https://www.washingtonpost.com/business/2023/06/11/weight-loss-ozempic-wegovy-insurance/?utm_campaign=KHN%3A%20First%20Edition&utm_medium=email&hsmi=262066865&hsenc=p2ANqtz-9rlvynBptFsvvj0doDkQYFbvNOgwtFzvPvqY3Lam5feDA5V4gdYZuELna20MTZAFOD_wqPN6Ijvzvmi)

**RELEVANT AMA POLICY:**

**Patient Access to Treatments Prescribed by Their Physicians H-120.988**

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

## SUMMARY OF FISCAL NOTES (I-23)

### **BOT Report(s)**

01	Employed Physicians	Moderate
02	Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies	Minimal
03	Update on Climate Change and Health – AMA Activities	Informational Report
04	Update on Firearm Injury Prevention Task Force	Informational Report
05	AMA Public Health Strategy: The Mental Health Crisis	Minimal
06	Universal Good Samaritan Statute	Moderate
07	Obtaining Professional Recognition for Medical Service Professionals	Minimal
08	AMA Efforts on Medicare Payment Reform	Informational Report
09	Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted	Informational Report
10	Medical Decision-Making Autonomy of the Attending Physician	Minimal
12	American Medical Association Meeting Venues and Accessibility	Minimal
13	House of Delegates (HOD) Modernization	Minimal
14	Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home	Minimal
15	Redefining AMA's Position on ACA and Health Care Reform	Informational Report
16	2023 AMA Advocacy Efforts	Informational Report
17	Specialty Society Representation in the House of Delegates - Five-Year Review	Minimal

### **CC&B Report(s)**

01	Physicians' Use of Social Media for Product Promotion and Compensation	Minimal
02	Research Handling of De-Identified Patient Data	Minimal

### **CEJA Report(s)**

01	Physicians' Use of Social Media for Product Promotion and Compensation	Minimal
02	Research Handling of De-Identified Patient Data	Minimal

### **CEJA Opinion(s)**

01	Responsibilities to Promote Equitable Care	Informational Report
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## SUMMARY OF FISCAL NOTES (I-23)

### CLRPD Report(s)

01	Women Physicians Section Five-Year Review	Minimal
02	Generative AI in Medicine and Health Care	Informational Report

### CME Report(s)

01	Leave Policies for Medical Students, Residents, Fellows, and Physicians	Minimal
02	Update on Continuing Board Certification	Informational Report
03	Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education	Modest
04	Recognizing Specialty Certifications for Physicians	Modest
05	Organizations to Represent the Interests of Resident and Fellow Physicians	Modest

### CMS Report(s)

01	ACO REACH	Minimal
02	Health Insurers and Collection of Patient Cost-Sharing	Minimal
03	Strengthening Network Adequacy	Minimal
04	Physician-Owned Hospitals	Informational Report
05	Medicaid Unwinding Update	Minimal
06	Rural Hospital Payment Models	Minimal
07	Sustainable Payment for Community Practices	Minimal

### CSAPH Report(s)

01	Drug Shortages: 2023 Update	Minimal
02	Precision Medicine and Health Equity	Minimal
03	HPV-Associated Cancer Prevention	Moderate
04	Supporting and Funding Sobering Centers	Modest
05	Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room	Moderate
06	Marketing Guardrails for the "Over-Medicalization" of Cannabis Use	Minimal
07	Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities	Minimal

## SUMMARY OF FISCAL NOTES (I-23)

### HOD Comm on Compensation of the Officers

01	Report of the House of Delegates Committee on the Compensation of the Officers	\$29,861
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### Report(s) of the Speakers

01	Report of the Resolution Modernization Task Force Update	Informational Report
02	Extending Online Forum Trial Through A-24	Minimal
03	Report of the Election Task Force 2	Minimal

### Resolution(s)

002	Support for International Aid for Reproductive Healthcare	Modest
004	Reconsideration of Medical Aid in Dying (MAID)	Modest
005	Adopting a Neutral Stance on Medical Aid in Dying	Modest
006	Inappropriate Use of Health Records in Criminal Proceedings	Modest
007	Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers	Modest
009	Physicians arrested for Non-Violent Crimes While Engaged in Public Protests	Moderate
201	Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care	Minimal
202	Protecting the Health of Patients Incarcerated in For-Profit Prisons	Modest
203	Anti-Discrimination Protections for Housing Vouchers	Minimal
204	Improving PrEP & PEP Access	Minimal
205	Cannabis Product Safety	Modest
206	The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice	Minimal
207	On-Site Physician Requirement for Emergency Departments	Modest
208	Non-Physician Practitioners Oversight and Training	Minimal
210	Immigration Status in Medicaid and CHIP	Modest
213	Health Technology Accessibility for Aging Patients	Minimal
215	A Public Health-Centered Criminal Justice System	Minimal
216	Saving Traditional Medicare	Moderate
217	Addressing Work Requirements for J-1 Visa Waiver Physicians	Minimal
218	Youth Residential Treatment Program Regulation	Modest

## SUMMARY OF FISCAL NOTES (I-23)

219	Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)	Modest
220	Merit-Based Process for the Selection of all Federal Administrative Law Judges	Minimal
222	Expansion of Remote Digital Laboratory Access Under CLIA	Modest
223	Initial Consultation for Clinical Trials Under Medicare Advantage	Minimal
224	ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers	Moderate
225	Antipsychotic Medication Use for Hospice Patients	Modest
226	Delay Imminent Proposed Changes to U.S. Census Questions Regarding Disability	Modest
234	Pharmacy Benefit Manager (PBM) Control of Treating Disease States	Modest
301	Clarification of AMA Policy D-310-948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure”	Minimal
302	Medical Student Reports of Disability-Related Mistreatment	Minimal
304	Health Insurance Options for Medical Students	Modest
305	Addressing Burnout and Physician Shortages for Public Health	Modest
306	Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies	Minimal
307	Re-evaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program	Moderate
601	Carbon Pricing to Address Climate Change	Modest
606	Prevention of Healthcare-Related Scams	Modest
801	Improving Pharmaceutical Access and Affordability	Minimal
802	Improving Nonprofit Hospital Charity Care Policies	Modest
803	Improving Medicaid and CHIP Access and Affordability	Minimal
804	Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity	Modest
805	Medication Reconciliation Education	Minimal
806	Evidence-Based Anti-Obesity Medication as a Covered Benefit	Minimal
807	Any Willing Provider	Moderate
808	Prosthodontic Coverage after Oncologic Reconstruction	Modest
809	Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion	Modest
811	Expanding the Use of Medical Interpreters	Minimal
812	Indian Health Service Improvements	Moderate

## SUMMARY OF FISCAL NOTES (I-23)

813	Strengthening Efforts Against Horizontal & Vertical Consolidation	Moderate
814	Providing Parity for Medicare Facility Fees	Moderate
815	Long-Term Care and Support Services for Seniors	Modest
817	Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations	Moderate
818	Amendment to AMA policy on healthcare system reform proposals	Moderate
819	Amend Virtual Credit Card Policy	Modest
820	Affordability and Accessibility of Treatment of Overweight and Obesity	Moderate
821	Modernizing the AMA/Specialty Society RVS Update Committee (RUC) Processes	\$4.4 Million Professional fees for data collection and hiring 2 new senior professional staff
901	Silicosis from Work with Engineered Stone	Moderate
902	Post Market Research Trials	Modest
903	Supporting Emergency Anti-Seizure Interventions	Minimal
904	Universal Return-to-Play Protocols	Minimal
905	Support for Research on the Relationship Between Estrogen and Migraine	Modest
906	Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices	Minimal
909	High Risk HPV Subtypes in Minoritized Populations	Moderate
910	Sickle Cell Disease Workforce	Moderate
913	Public Health Impacts of Industrialized Farms	Moderate
914	Adverse Childhood Experiences	Modest
915	Social Media Impact on Youth Mental Health	\$251,462 Convene expert panel, develop & disseminate educational materials
916	Elimination of Buprenorphine Dose Limits	Moderate
921	Addressing Disparities and Lack of Research for Endometriosis	Modest
922	Prescription Drug Shortages and Pharmacy Inventories	Moderate
923	Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation	Modest

**Minimal - less than \$1,000**

**Modest - between \$1,000 - \$5,000**

**Moderate - between \$5,000 - \$10,000**